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ALCOHOLISM SERVICES HANDBOOK FOR PREPAID GROUP PLANS

APRIL 1982

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Public Health Service
Alcohol, Drug Abuse, and Mental Health Administration

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U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Public Health Service
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National Institute on Alcohol Abuse and Alcoholism
5600 Fishers Lane
Rockville, Maryland 20857

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This publication was prepared for the National Institute on Alcohol Abuse and Alcoholism by Group Health Association, Inc. under Contract No. ADM 281-80-004. F. Barrie Montague served as Project Officer.

The opinions and viewpoints expressed herein do not necessarily reflect the policies of the National Institute on Alcohol Abuse and Alcoholism.

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* Both Appendix D and E were originally part of the GHAA Study entitled "Alcoholism Treatment Programs Within Prepaid Group Practice HMOs: A Final Report," printed in April, 1982, under Contract # ADM 281-80-004 with the National Institute on Alcohol Abuse and Alcoholism.

I. INTRODUCTION

The Group Health Association of America (GHAA) has completed a demonstration project and evaluation funded by the National Institute on Alcohol Abuse and Alcoholism (NIAAA) of the Department of Health and Human Services (HHS) to demonstrate the feasibility of comprehensive alcoholism services in health maintenance organizations (HMOs) and to evaluate the costs and benefits derived from the demonstration. In particular, treatment outcomes and subsequent patterns of medical utilization were noted. Utilization was compared to a group of enrollees not identified as alcoholics matched for age, sex and time in plan.

This handbook is intended to address areas of consideration for group and staff model HMOs in assessing the feasibility, planning, developing and managing of alcoholism treatment services. It is written from the perspective of the HMO administrator and both administrative and treatment factors are discussed.

The manual is organized into five sections:

- Introduction
- Planning for Implementation
- Selection of Appropriate Treatment Modalities
- Program Monitoring and Program Evaluation
- Alcoholism Treatment in Individual Practice Associations

These additional materials are also included in the handbook:

- Appendices

- Glossary
- Bibliography

The purpose of this updated handbook is to provide a resource for HMO managers, both lay and medical, in the design of the benefit package and the services to be provided to enrollees with alcohol problems within legal requirements, the recognition of sound management principles and the fiscal viability of the organization.

A. GENERAL BACKGROUND

The treatment of alcoholism and alcohol abuse has received increasing attention in the past decade, primarily through federal funding initiatives which have created a more receptive climate for treatment. A series of federal statutes has outlined the federal role, beginning with the enactment of the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act in 1970. The support of the federal authorities has continued through extension of the prevention, treatment, and rehabilitation mandate by the Congress and the Administration, by continued funding, and by incorporating alcoholism treatment into basic service requirements of community mental health centers and health maintenance organizations (HMOs). At the present time funding by the federal government for community alcoholism services has been severely curtailed.

Alcoholism is currently recognized by most professionals in the health field as a treatable disease. The problem of alcoholism, however, has wider ramifications, not only in the health field, but on society as a whole.

Mortality rates of alcoholics, for example, are 2.5 times greater than for non-alcoholics (in one study group). Although mortality rates, from some causes such as cirrhosis, have decreased, others, such as highway accidents, have increased to offset this decline.[1/]

Alcohol abuse can result in a wide variety of health problems, such as heart disease, high blood pressure and stroke. Evidence is also being accumulated showing that alcohol abuse during pregnancy can be detrimental to the development of the fetus, including the fetal alcohol syndrome (FAS). FAS can entail mental retardation, facial abnormalities, poor motor development, and extreme growth deficiency. There is also a relationship between heavy alcohol consumption and increased cancer risk at specific body locations (such as the mouth, pharynx, larynx, and esophagus).[2/]

The social implications of alcohol abuse are many in addition to physical health problems, extending the destructiveness of the disease to the world outside of the individual. Between 35 and 64 percent of drivers in fatal accidents are under the influence of alcohol. As many as 50% of those dying in falling accidents had been drinking. An estimated one-half of adult fire deaths involve alcohol. Between 50 and 68 percent of all drowning victims were reported to have been drinking. Alcoholics have a high suicide rate. The risk of suicide for alcoholics is as much as 30 times greater than that for the general population.[3/]

[1/] Fourth Special Report on Alcohol and Health, DHHS, Jan. 1981, p. 3.
[2/] *Ibid.*, pp. 3, 4, and 5
[3/] *Ibid.*, p. 6.

There are also economic costs concomitant with alcohol abuse, both to the individual and to society at large. These costs are difficult to document, yet in terms of production loss, health care expenditures, violent crimes, motor vehicle accidents, fire losses and social responses, misuse has been estimated to cost $42 billion a year.[4]

For these reasons, alcoholism is seen to be a disease of increasing significance, a disease necessitating the focus of many members and segments of society. A number of hospitals and other health care providers in the nation treat countless alcoholics and alcohol abusers on a daily basis. Groups such as medical professionals, social scientists, and legal advocates have rallied in the movement to establish effective and comprehensive treatment programs.

An important concept in the effective treatment of alcoholism and alcohol abuse is a continuum of care which addresses the complex array of problem situations--medical, psychological, and environmental--which may be encountered in the alcohol abusing patient's day-to-day existence. It is not uncommon for an alcoholic to be treated for the physical problems resulting from drinking and to be discharged to what, for the patient, is still an untenable situation without alcohol; the psychological problems may not have been dealt with adequately. This superficial treatment is due in part to the lack of information regarding recognition and treatment of alcoholism. In addition, there is typically a lingering stigma attached to the diagnosis of alcoholism as well as a stereo-typical view of the alcoholic as "down-and-out, skid-row type of individual" to which most patients, or the general public, do not conform.

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[4] Ibid., p. 7.

The National Institute on Alcohol Abuse and Alcoholism has estimated the consequences of misuse of alcohol as follows:[5]

- The overall economic cost associated with misuse of alcohol was estimated at $43 billion for 1975
- The costs associated with lost productivity--production of goods and services--due to the reduced productivity of alcoholic male workers approximated $19.64 billion
- Expenditures for alcohol-related health and medical services approached $13 billion
- Estimates of alcohol-related mortality range up to 205,000 deaths per year, or 11% of total deaths in 1975

B. LEGISLATIVE OVERVIEW

Federally funded HMOs are required to provide or arrange for the provision of basic health services to their members as needed. These requirements were an integral service component of the HMO Act of 1973, and the subsequent HMO Amendments of 1976 (P.L. 94-460) and 1978 (P.L. 95-559). Specific requirements for alcoholism services include:

- Provision of basic health services, medical treatment, and referral services for the abuse of or addiction to alcohol and drugs

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[5] Fourth Special Report on Alcohol and Health, DHHS, Jan. 1981.

- Provision of medically necessary emergency health services
- Provision of short-term outpatient evaluative or crisis intervention mental health services, up to 20 visits

In addition, the 1976 HMO Amendments include the following provisions which were left unchanged in subsequent amendments:

- Each supplemental benefit need not be offered; therefore, only those supplemental benefits for which there is a demand will be offered. Because of this option, a plan does not have to supply alcoholism benefits to all enrollees, beyond the basic requirements.
- A minimum benefit package which exceeds basic requirements by inclusion of one or more specified supplemental benefits is allowable.

Regulations issued in 1980 indicated that:

- Diagnosis, medical treatment and referral services (including referral services to appropriate ancillary services) for the abuse of or addiction to alcohol and drugs:
  - Diagnosis and medical treatment for the abuse of or addiction to alcohol and drugs shall include detoxification for alcoholism or drug abuse on either an outpatient or inpatient basis, whichever is medically determined to be appropriate, in addition to the other required basic health services for the treatment of other medical conditions;

- Referral services may be either for medical or for nonmedical ancillary services. Medical services shall be a part of basic health services; nonmedical ancillary services (such as vocational rehabilitation and employment counselling) and prolonged rehabilitation services in a specialized inpatient or residential facility need not be a part of basic health services.

An HMO, however, may offer residential or inpatient care for alcoholics as either a basic or a supplemental benefit. Section 110.103 states:

- Each HMO may provide to its members any of the following health services, which may be limited as to time and cost:
  - Services of facilities for intermediate and long-term care;
  - Vision and hearing care not included as a basic health service;
  - Dental services;
  - Mental health services not included as a basic health service;
  - Long-term physical medicine and rehabilitative services (including physical therapy);
  - Prescription drugs prescribed in the course of the provision by the HMO of basic outpatient or supplemental health services; and
  - Other health services which are not included as basic health services.

Further changes were made in the 1981 Amendments. Alcohol and drug abuse were retained as basic benefits, despite legislative efforts to move them to the supplemental category. Among the provisions of the

1981 Amendments were availability of loans and loan guarantees to profit as well as non-profit HMOs, added new solvency requirements, modified community rating and deleted requirements concerning administration and evaluation of the program. While not affecting alcohol abuse and alcoholism services directly, the 1981 Amendments point to greater flexibility by HMOs (which encompass prepaid group plans) in designing, pricing and marketing.

Alcoholism services may be encompassed under intermediate, long-term care or long-term mental health services. Supplemental benefits may be charged on a fee-for-service or prepaid basis. If the benefit is prepaid premiums must be set on community rated or community rated by class basis. For prepaid supplemental benefits, rates are set using enrollees who purchase that benefit as the "community." Co-payments cannot exceed 50% of "costs" of any single basic or supplemental service or 20% of total costs of all services. Moreover, costs cannot exceed 100% of the premium the enrollee would be required to pay without copayments.

C. STATE INSURANCE PROVISIONS MANDATING COVERAGE FOR ALCOHOLISM TREATMENT

In an unpublished report prepared for the National Institute on Alcohol Abuse and Alcoholism (NIAAA), Hallan and Montague[6] found that a majority of the 47 responding states indicated that while health insurance plans should provide coverage for alcoholism treatment, insurance regulations did not assure adequate coverage. Additionally, the insurance industry has shifted from active opposition to health insurance coverage for alcoholism treatment to more flexible consideration by providing useful information and aid in the preparation of legislation.

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[6] Hallan, Jerome B. and Montague, F. Barrie, "Health Insurance Coverage for Alcoholism," May 1975. An unpublished report to NIAAA.

State insurance regulatory agencies, and labor and management, have indicated that alcoholism treatment coverage is desirable, without overwhelming concern over treatment costs. This is an acknowledgement that alcoholism is treatable and that assisting employees through treatment will ultimately reduce industry recruitment and retaining costs.

By December, 1978, thirteen states had enacted enabling legislation requiring mandatory inclusion of alcoholism treatment benefits for group health insurance plans:

- Connecticut
- Hawaii
- Illinois
- Kansas
- Massachusetts
- Minnesota
- Mississippi
- Missouri
- New Jersey
- North Dakota
- Ohio
- Washington
- Wisconsin

Eleven other states have enacted legislation making group health insurance coverage of alcoholism treatment benefits an option:

- California
- Colorado
- Kentucky
- Louisiana
- Maryland
- Michigan
- New York
- Oregon
- South Dakota
- Tennessee
- Virginia
- Texas

As of 1981, sixteen of the twenty nine states report that their statute applies to HMOs. These may be mandatory as in Minnesota or optional as in Texas. An HMO should determine what benefits are required to be offered under state law. In 1981, the National Association of Insurance Commissioners developed a model law which originated from a task force on alcohol and drugs. Actual benefits provided by statute range from no specification to a fixed number of days of inpatient care; many do not specifically address outpatient treatment.

D. USE OF PREPAID GROUP PLANS AS ALCOHOLISM TREATMENT RESOURCES

Utilizing prepaid group plans as a resource in alcoholism treatment allows employer-enrolled patients to seek treatment without fear of job loss or "exposure." Because of their emphasis on health maintenance and preventive care, prepaid plans are in an excellent position to provide services for the alcoholic member. Specifically, the prepaid group plan may:

- Provide for the education, early diagnosis and treatment, and efficient management of alcoholism
- Offer member access to community alcoholism resources through a referral system

Treatment programs supported by business and industry can be especially effective in early identification of employees with health problems. Such programs report the highest rates of recovery from alcoholism, a desirable opportunity for interface with prepaid plans.

There could be considerable advantages to the prepaid plans that provide alcoholism treatment. It has been shown that many physical as well as psychological problems are linked to alcoholism. For example, Exhibit I, following this page, shows the absence rates of alcoholics and controls by diagnostic category in one widely-quoted industry study. Moreover, the GHAA study found absenteeism and reprimands at work declined after patients entered treatment in an HMO setting. This finding is one that should be of interest to marketing departments. Additionally, Wersinger, et al recently found significantly higher utilization rates before treatment for alcoholic patients within the HMO setting both for ambulatory (23% higher) and inpatient (12 times greater) visits as compared to matched controls.[7/] The result of a study by Sandra L.

7/ Wersinger, R., Roberts, J., Roghmann K., and Wells S., "The Inpatient Hospital & Ambulatory Utilization Experience of an Alcoholic Population Compared to a Matched Control Group Within an HMO," Presented at the Group Health Institute, 1978.

Exhibit I

ABSENTEE /FREQUENCY RATES OF ALCOHOLICS AND CONTROLS BY DIAGNOSTIC CATEGORY

	A Frequency Rate Of Alcoholics	C Frequency Rate Of Controls	A/C Ratio Of Frequency Rates
Respiratory infections	38.5%	22.5%	1.7
Digestive disorders	28.1	11.9	2.4
Musculoskeletal disorders	14.5	5.3	2.7
Virus infections, unspecified	6.9	5.2	1.3
Cardiovascular disease	5.2	2.7	1.9
Accidents	4.6	1.3	3.5
Alcoholism	3.4	0.0	--
Neurological disorders	3.0	2.0	1.5
Genitourinary disorders	2.5	3.9	0.6
Mental illness	2.0	0.6	3.3
Other illnesses	9.8	4.9	2.0
Unknown	10.2	5.6	1.8
TOTAL	128.8	65.9	1.0

Source: Pell, S. and C.A. D'Alonzo. "Sickness, Absenteeism and Alcoholics," Journal of Occupational Medicine, 12: 198-210, (June) 1970.

Putnam, a researcher at the Rhode Island Group Health Association, suggest that alcoholism treatment is associated with substantial reductions in medical care utilization.[8/] The final report of the Group Health Association of America's alcoholism study also documents a trend of lower utilization for both ambulatory and hospital care for alcoholics who have presented for treatment.[9/] Studies have related alcohol consumption to various presenting morbidities such as gastrointestinal disorders, liver disease, cancer, and hypertension.[10/]

Effective treatment of alcoholism might reduce the need and cost for health services necessitated by related disorders, as suggested by findings of the Group Health Association of America research and demonstration grant. The final report of the GHAA project (1982) indicated reductions in rates of utilization from .94 visits per member per month during the 2 year period prior to treatment intake, to .77 visits 48 months following intake. Among a matched comparison group in two of the plans the number of visits doubled from .14 to .28 per member per month. More importantly, the type of utilization changed dramatically

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[8/] Putnam, Sandra L., "Short Term Effects of Treating Alcoholics for Alcoholism on Their Utilization of Medical Care Services in a Health Maintenance Organization." Paper presented at the 31st Annual Group Health Institute, Washington, DC, June 14-17, 1981.

[9/] Plotnick, David E., Adams, Kenneth M., Hunter, Harold R., and Rowe, Jonathan C., "Alcoholism Treatment Programs Within Prepaid Group Practice HMOs: A Final Report," GHAA, 1982.

[10/] Fourth Special Report on Alcohol and Health, DHHS, Jan. 1981.

through the follow-up period, with emergency services reduced from 31% to 9% of all visits, while the proportion of emergency visits by controls remained unchanged. Scheduled visits went up from 59% to 71%, and physician encounters went down from 70% to 51%, clearly indicating more appropriate and less costly utilization following entry into treatment.[11] Hallan's study of alcoholism coverage for California state employees found a reduction in inpatient encounters for alcoholics and family members within the prepaid group practice setting following treatment, and an overall reduction in utilization costs.[12] Sherman, et al recently studied the health care utilization experience of alcoholics who participated in treatment as compared to "nonparticipating" alcoholics within the Kaiser-South system, and found a reduction in total costs of $13 per year for the participating group, as compared to an increase of $305 per year for the nonparticipating group.[13] Alcoholics, the GHAA project found, despite reductions in ambulatory utilization after treatment, remain higher than average utilizers of care. Nevertheless, it appears that the cost of treating alcoholics enrollees is far less than the cost of not treating them.

Additionally, the prepaid group plan brings together a defined population with providers, facilities, and a financing system. The prepaid group plan offers a variety of the services and treatment modalities needed by an alcoholic patient; therefore, such an organized system has the potential to coordinate the range of health care services needed to deal with the problems of alcoholism.

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[11] "Alcoholism Within Prepaid Group Practice HMOs," GHAA, December 1978.

[12] Hallan, J. B., and Holder, H. D., Study of Health Insurance Coverage for Alcoholism for California State Employees, DHEW, NIAAA Contract # ADM 281-75-0027, December 1976.

[13] Sherman, R. M., Reiff, S., and Forsythe, A. B., "Utilization of Medical Services by Alcoholics Participating in an Outpatient Treatment Program."

E. TARGET POPULATION

Both a prepaid plan's entire staff and its membership should be educated and aware of the issues contained in this handbook. The target treatment population should be viewed in a broad perspective. Rather than limiting the program to treating only the alcoholic, it may be of benefit to attempt to identify and to treat the "problem drinkers," the asymptomatic alcoholics," and other persons such as family members whose lives are negatively affected by the consumption of alcohol, but who, under usual circumstances, would not likely be identified or placed in any kind of treatment. Health education was until recently required as a basic benefit for federally qualified HMOs.14/ Alcohol and other substance abuse are part of any comprehensive health education program. Materials are available from numerous sources including the National Clearinghouse for Alcohol Information. Preventive efforts often target on particular age groups or occupational groups. Likewise health screening programs, which should include screening for drinking problems, are focused on specific groups at risk.

14/ Boyajy, Thomas G., and Adams, Kenneth M., Alcoholism Treatment Programs Within Prepaid Group Practice HMOs: An Update, GHAA, April, 1980.

The prepaid plan management and staff should recognize that, theoretically, its entire membership is at risk, either directly or indirectly. Unless the providers are given sufficient information to entertain and detect the likelihood of an alcohol-related problem, members may continue to suffer progressively and perhaps needlessly from their own misuse of alcohol or misuse on the part of a family member.

Finally, other target populations include the employee and consumer groups that form the marketing effort of the plan. Education about health problems such as alcoholism is an effort that can at the same time inform and build good will with groups that may pay dividends to the prepaid plan in increased penetration. Prepaid group plans may also elect to establish their own occupational programs to assist their employees and membership in identifying and treating alcohol abuse during the incipient stages of the disease, often manifested within the workplace, as was done at the Rhode Island Group Health Association. It has been found that alcoholism programs in the workplace have high success rates.[15] The question of whether a plan considers establishing an occupationally-based program depends on economic, marketing and organizational factors beyond the scope of this handbook.

15/ Fourth Special Report on Alcohol and Health, DHHS, Jan. 1981. p. 9.

II. PLANNING FOR IMPLEMENTATION

The cornerstone of developing an adequate and feasible alcoholism treatment component, or benefit package, within a prepaid group plan is planning and organization of resources.

During the planning stages, the plan should estimate the need and demand for alcoholism treatment services. As is true for any other benefit, a stable membership is necessary to plan for orderly delivery of services and cash flow. The assessment of need and demand would also be important for the development of preventive strategies to combat the abuse of alcohol and to limit the adverse health outcomes of those members already abusing alcohol.

A. ADMINISTRATIVE ASSESSMENT

Management must ask itself a series of questions to determine the comprehensiveness and configuration of alcoholism benefits:

1. Is the plan in a mode where all resources and planning must be devoted to survival as an organization or is it able to address such issues as improving benefit packages, delivery arrangements, or educational and preventive activities? GHAA rendered technical assistance on alcoholism services to over twenty HMOs. The major reason for HMOs not acting on the technical assistance recommendations was that plan survival took precedence over additional services. The attainment of economic viability is the goal of any new HMO. It was found that those HMOs whose future was more secure were those who accepted and implemented enhanced

alcoholism services.

2. What is the extent of the problem within the HMO? Are physicians aware of the problem? Are receptionists, social workers, or health educators aware of the problem? If there is a mental health unit, do they treat persons with alcohol problems? The perception of providers and other staff may be indicative of unmet needs.

Information on the extent of the problem can be developed by querying staff in urgent visit units and reviewing claims for emergency care. Hospital case review is a sensitive indicator of potential alcoholism of the HMO-enrolled population. The medical director of the Health Alliance Plan reviewed each hospitalization for underlying alcoholism and discovered many cases in which alcohol abuse was a contributory or complicating factor. This was a powerful case-finding tool. Unfortunately, the prevalence of alcohol problems may be high but staff may not be aware of it, either because of lack of training or denial of the problem. The death rate from cirrhosis of the liver, estimates from the state alcoholism authority, and to a lesser extent DWI arrests can indicate the extent of the problem.

3. What treatment and prevention resources exist in the HMO? In an HMO there may be resources already treating alcoholic problems or capable of addressing these problems. Areas such as urgent visit units, mental health departments, telephone triage and family practice/internal medicine are likely to already treat alcoholics. An assessment

of how this existing care can be improved and what additional programs or personnel are needed ought to be conducted.

4. Can a physician be identified who will take responsibility for the alcoholism program in the HMO? In the GHAA demonstration sites, this individual in the Health Alliance Plan was the medical director, the head of ADD in the Arizona Health Plan and the head of the alcoholism program in Kaiser-Portland and Kaiser-Los Angeles. All of these physicians were trained in other specialties (pediatrics, family medicine and internal medicine) and were highly regarded by their colleagues. It appeared that provider attitudes underwent a change by the presence of a colleague who was an informed advocate.

5. What alcoholism treatment and prevention resources exist in the community? Since referral to medical and non-medical programs are part of the basic benefit package for federally qualified HMOs, these programs should be identified and evaluated. The identification and evaluation ought to be done in light of the HMO's own benefit packages. If, for example, the HMO is located in a state where residential treatment is mandated by state insurance law, then local programs should be visited and assessed.

Factors to be considered are: 1) length and modalities of treatment; 2) cost of treatment; 3) location; 4) reputation and appearance of the facility; and 5) willingness to work with and contract with the HMO. In addition to treatment programs, many preventive and educational resources may be available to provide the HMO with audiovisual materials, lecturers, or consultation on alcoholism. Finally, the HMO should be aware of help from the fellowship of Alcoholics Anonymous, Al-Anon for families of alcoholics, and Alateen for adolescents affected by the disease in their environment. These voluntary groups are invaluable allies to health care providers treating alcoholic patients.

B. CONSIDERATION OF THE DESIGN OF ALCOHOLISM BENEFITS

Consider the advantages of basic alcoholism benefits more comprehensive than that required by federally qualified HMOs. Often this decision is a result of state insurance requirements. Even when not required by any governmental authority, however, it may be advantageous to have more comprehensive benefits for marketing the plan and for effective health delivery. The four GHAA demonstration sites continued their largely outpatient oriented programs as a basic benefit with no additional premium because more patients used the care appropriately, because the programs were seen to be clinically effective, and because there was a need for these services in the enrolled population.

Consider what supplemental benefits should be offered. These benefits are available to requesting groups or when collective bargaining for benefits is involved. Supplemental benefits premiums are separately calculated on a fee-for-service or prepaid basis in federally qualified HMOs. If prepaid, they must be community rated (i.e., all enrollees with that benefit pay the same premium on a per person or per family basis--although the subsequent amendments allow some modification to community rating by actuarial class). This type of rating requires an assessment of demand by groups that purchase care from the HMO.

Another benefit design question is whether to make the benefit alcohol-specific or include drug abuse benefits. The additional cost of including drugs is fairly small and if the population in the HMO is homogeneous, drug-alcohol interactions can be uncovered. Most HMOs market a combined drug-alcohol benefit. Most enrollees seeking care under combined benefits have primarily alcohol problems (many alcoholics, however, would be less inclined to purchase them). Nevertheless, regardless of the semantics of the benefit, treatment personnel will treat persons addicted to alcohol and drugs (usually prescription drugs). Such was the case at Kaiser-Fontana which uses its acute care inpatient hospital for detoxifying from both alcohol and barbiturates which they term "major withdrawal."

Consider the extent of cost sharing in the benefit. Copayments are limited for federally qualified HMOs to 20% of all services and 50% of any single service. Copayments are used to discourage overutilization and to generate additional revenue. Since alcoholics appear reluctant to seek treatment, copayments for initial visits are not recommended. It was found in Kaiser-Portland that alcoholics with a 50% copayment used fewer services than those for whom services were "free" (i.e., no copayments). This is not unexpected and depends on optimum numbers of services to sustain a good treatment outcome, something that is exceedingly difficult to predict. One method of encouraging contact and recognition is to have initial visits free with either level or ascending copayment thereafter.

Copayment requirements should be consistent with other benefits. If anything, an HMO should be wary of copayments for alcoholism treatment because of the difficulties in treatment arising from denial of the problem.

One area that plagues alcoholism treatment is a revolving door of detoxification. While this is a phenomenon of public treatment programs, it is not unknown in the more medical mainstream setting of the HMO. Increasing cost-sharing by patients for repeated detoxifications may be tried. Cost sharing may be linked to a patient's therapeutic contract. A contract setting forth respective obligations of patient and provider has been found to be a useful tool in many alcoholism programs.

Once benefits are defined it is the responsibility of the HMO's clinical staff to delineate treatment objectives which can be used by providers and administration to select and implement a service delivery configuration.

C. ESTABLISHING TREATMENT PROGRAM OBJECTIVES

After determining the needs of the membership target population in the service area and the plan's capacity to provide needed services, the plan should establish specific alcoholism treatment objectives. An example of a specific alcoholism treatment objective would be: To identify acute alcoholism problems occurring in the plan and to refer such individuals to appropriate treatment within 24 hours. Treatment objectives should be amenable to measurement and to coordination with the plan's quality assurance program. The following should be considered in developing treatment objectives.

(1) Medical Treatment for Alcohol Abuse or Alcoholism

The alcoholism treatment program should relate closely to all other basic and supplementary services, with provision made for continuity of care for individuals requiring other plan services in addition to medical treatment for alcoholism. Alcoholism treatment should not be denied because a member has previously withdrawn from treatment against medical advice or because of a member's relapse. The plan should construct written guidelines for the staff of the medical or ancillary services for the identification of and response to alcoholism and alcohol-related problems.

The medical alcoholism treatment program should include a broad range of treatment approaches with emphasis placed on outpatient or intermediate treatment and follow-up services. To ensure adequate planning and ongoing evaluation of the patient's progress and treatment the plan should develop a tracking system. Most importantly, in collecting information and monitoring patient progress, the HMO should develop written policies to assure the confidentiality of patient records. When systems have been developed and a program constructed, the availability of medical treatment for alcoholism should be brought to the attention of all plan members.

(2) Referral Services

Specific written referral procedures and treatment resources for those members seeking treatment should be part of an inservice training program for staff members, and should be made routinely available to plan enrollees. The plan staff should have a complete directory of referral resources, and affiliation agreements with referral resources should be developed to assure clear definition of the roles and responsibilities of the treatment resources and the plan.

(3) Medically Necessary Emergency Health Services

Emergency health services should include emergency treatment for alcohol abuse and alcoholism. Program staff should receive specific training for identification and emergency treatment of alcohol toxicity and toxic reactions as a result of combining alcohol with prescribed as well as nonprescribed and illicit drugs. Specifications for emergency services should include procedures for identification and triage for members with alcohol and/or drug problems and should be closely aligned with the medical treatment and referral components. Emergency services may be provided in-plan or through other community service providers.

Some examples of emergency treatment centers in the community are:

- General hospitals
- Special alcoholism treatment centers

- Health clinics
- Community mental health centers

(4) Outpatient Mental Health Services

The plan should develop methods for ready identification and screening of alcoholic persons seen in outpatient evaluative or crisis intervention mental health service, or any general urgent care or walk-in program component, within specific confidentiality guidelines. The staff employed in these types of program components should be trained to evaluate the nature and extent of the alcoholism problem presented by the individual member, and should be similarly familiar with available resources both in- and out-of-plan for referral.

(5) Other Considerations

A developing plan may not be capable of implementing a wide range of services to its members needing alcoholism treatment. As a practical matter, a separate program is not feasible until a plan reaches an enrollment of 10-15,000. By the same token, a large plan can add other modalities such as the development of 10-15 bed alcoholism inpatient unit for major withdrawal by Kaiser-Fontana. Most plans would provide those services which are available to all members and will arrange for referral for long-term treatment.

However, keeping alcoholism treatment services in-plan would have particular advantages:

- Administration would have greater opportunity for cost and quality controls

- Follow-up and continuity of care would be easier
- Records would be more complete
- Plan staff could be taught more easily to identify and deal with alcoholism problems, and stigmatized attitudes toward alcoholism would be more amenable to change than if services were provided by outside resources

After careful consideration of needs and establishment of treatment objectives, a service delivery configuration should be contemplated and selected.

D. SELECTING A SERVICE DELIVERY CONFIGURATION

Once treatment needs have been defined and treatment objectives have been established, the plan would be able to consider a service delivery configuration. Part III will delineate the range of services generally applicable to the treatment of acute and chronic alcohol abuse. At this point in development, the plan would decide what services to make available in terms of its basic and supplemental benefits. It is at this juncture that a plan must critically assess its own capability to deliver needed services through existing resources such as primary care or mental health, its desire and capability to establish a new service component, or the necessity to arrange for service provision by outside providers.

No prepaid plan is required under any mandate to develop the full range of services described either in-house or through external linkages. Each plan, however, must consider the desirability of developing a comprehensive service package because of the clear need for continuity of care. Thus, the alternatives would be to:

- Provide all needed services in-house
- Provide identification, acute treatment, and referral services in-house, and contract out for other services
- Provide only identification, emergency, and referral services in-house, and contract out other services
- Provide only identification, emergency, and referral services in-house

There might be additional variations depending on the inclinations of the plan, the demand for services, and the plan's assessment of its own capabilities.

Taking detoxification as an example, the plan would have to determine how members would need to be detoxified and how the medical management of these individuals would relate to the rest of the plan. Decisions such as the setting of a medical versus a social treatment model would need to be made. The plan would have to determine whether detoxification were to be on an inpatient or outpatient basis, or both, and could set criteria for the determination of this decision. The Arizona Health Plan, for instance, has demonstrated through the NIAAA/GHAA project that patients can be detoxified effectively on an outpatient basis in the overwhelming majority of cases.

It would be important for the plan to determine whether hospitals used by the plan were capable of providing inpatient detoxification. Although the American Hospital Association encourages acute general hospitals to develop the capability to detoxify inpatients for alcohol as well as opiates and barbiturates, many hospitals do not have this capability. HMO regulations require a written agreement when contracting for these services, unless it can be demonstrated that these services are seldom used. An additional factor would be that the quality and acceptability of external resources should be taken into account before entering into such agreements.

In deciding a clinical configuration the plan should:

- Determine from enrollment projections and community statistics (needs assessment) the extent of the alcoholism problem, and estimate the number of persons in both the service and target populations involved
- Determine optimum modalities and treatment strategies. How many will need inpatient detoxification? Would any changes need to be made in planning for emergencies? What kind of mental health evaluation, counseling, and crisis intervention would be needed?
- Determine from the plan's marketing staff whether demand exists among member and/or potential member groups for supplemental alcoholism benefits. If this is the case, estimate the number who would purchase the benefit, the number who would use it, and the costs (per service, per patient and per member-month) for service provision.

- Assess the alcoholism treatment resources in the community:
  - What services do they provide?
  - What clients do they serve?
  - Are there populations not being reached?
  - Do they have waiting lists or excess capacity?
  - Are the location, facilities, staff, client population, and image in the community acceptable to alcoholics in the community, or to the plan membership?
  - Are there gaps in the services?
  - What are the attitudes and assumptions of various community alcoholism treatment programs about serving plan members? Would they be willing to cooperate, to accommodate the plan with respect to records, hours of operation, or development of a formal contractual arrangement?
- Assess the capacity of the plan to provide for the needs of members with alcoholism problems:
  - Does the plan have access to appropriate inpatient beds?
  - Does the plan have the emergency services capability to treat alcohol-related emergencies, such as acute toxicity?
  - Does the plan have a program to provide crisis information, counseling, and follow-up?
  - Is there an appropriate consumer education program regarding alcohol abuse and possible consequences? Is someone on staff aware of community education resources?

- Assess attitudes and capabilities among plan providers (physicians, nurses, and so on) and the local medical community to determine the extent and strategy of provider education needed
- Match needs of the membership with plan and community alcoholism treatment resources

If it is deemed that the plan must contract out some services, there could be a number of contractual possibilities available to a plan attempting to develop services for alcoholics. There are numerous alcoholism programs both profit and non-profit. An important document when the HMO contracts out is the written agreement. A contract or written service agreement should contain the following elements:

- The time in which the agreement is in force
- The services to be provided by the contracting alcohol treatment agency
- The method of payment
- The amount of payment (per service, per capita, etc.)
- Record keeping requirements and access with assurances of confidentiality
- The mechanics of the referral process

The plan could contract with a community mental health center (CMHC) for alcoholism treatment as well as mental health services.

An example of an agreement on a fee-for-service basis with a

CMHC is that made by the Genesee Valley Group Health Association of Rochester, New York, for general psychiatric services provided by the Rochester Mental Health Center. The advantages noted by the Genesee Valley Group Health Association were:

- Relatively low cost for services rendered by a specialized staff
- Nonduplication of community-based services

Potential disadvantages anticipated included:

- Loss of client's identification with the plan and general loss of communication with the client
- Lack of client progress feedback from the CMHC

The Genesee Valley Group Health Association has not experienced either of these disadvantages; it has insisted, however, on receiving prompt and detailed progress reporting before payments are processed to ensure the receipt of timely and appropriate feedback. Another long-standing arrangement with a community mental health center is between Group Health Association of Northeastern Minnesota and the Range Mental Health Center.[1/]

A plan might also contract with a private or voluntary psychiatric hospital or clinic. The advantage of this arrangement would be the control inherent in contracting with a single provider under no obligation to serve an entire geographic area and are generally run in accordance

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[1/] This arrangement has been detailed by David Serwer in the proceedings of the conference on Financing Alcoholism Services at the 1980 Group Health Institute.

with accepted business principles. The disadvantages could be that private (profit) and voluntary (nonprofit) facilities could have incentives to maximize revenue and keep beds and treatment slots filled. This would create the potential for overuse if the facilities were reimbursed on a fee-for-service basis. Another potential problem could be that these facilities might lead to the inappropriate referral of difficult patients to public facilities. This problem could be met by the facility underwriting part of the risk and providing services on a capitated basis. This arrangement was used in Minneapolis where the Medcenter Health Plan (an HMO) has contracted with the Metropolitan Clinic for inpatient and outpatient alcohol, mental health, and drug abuse services for a capitated payments.

A plan could arrange with an acute care general hospital for detoxification and alcohol-related hospitalization. This arrangement is used by the Group Health Association in Washington, D.C. and is common among plans not owning their own hospitals. The success of this arrangement would depend on the plan's control over admissions, length of stay, and treatment.

Another variation would be for a plan to contract with a psychiatric hospital for detoxification and acute psychiatric care while retaining responsibility for other medical care and/or outpatient services. If this alternative is considered, the plan's medical staff should make an assessment of the facilities to be used.

The plan might also make arrangements with a publicly funded alcoholism treatment program. The Watts Foundation, for example, in which the House of Uhuru treats both alcoholics and drug abusers with various modalities, is utilizing this model.

Thus, the service delivery configuration, in terms of basic and supplemental benefits and who would provide what treatment, is the essence of the plan's alcoholism treatment program. Configuration decisions must be made early in the planning effort to facilitate such later planning and development activities as determination of plan staffing needs, delineation of plan administrative requirements, and negotiation of treatment contracts with external providers.

E. DEVELOPING ADMINISTRATIVE POLICIES AND PROCEDURES

After the plan has determined the basic structural format for alcoholism treatment services, administrative mechanisms should be established to implement the program. It would be necessary to develop policies and procedures defining the:

- Plan's administrative framework
- Regulations, guidelines, and standard operating procedures, including provisions for the following:
    - Confidentiality
    - Referrals and identification procedures
    - Monitoring and coordinating procedures
    - Management coordination with contractor services
- Organizational structure, lines of authority, responsibilities of each department, and the roles of key staff positions

The policies and procedures should be in writing, available to all staff, and periodically updated. In addition to these policies and procedures the plan might find it beneficial to develop a detailed performance plan and milestone chart for the first six months of operation. The performance plan and milestone chart would provide each department with short-term implementation goals and progress measurements during the implementation phase.

F. ENLISTING THE SUPPORT OF HMO PROVIDERS & ADMINISTRATORS

A critically important factor in the successful implementation of alcoholism services within an organized health system is support and commitment from plan decision makers and providers. Plan administrators must be convinced of the need, feasibility, and effectiveness of alcoholism treatment, and be willing to accept alcoholism as a disease entity that falls within the plan's responsibility to provide comprehensive health services, just as that responsibility encompasses cancer, diabetes, or cardiovascular disease.

As stated in the Kaiser-Portland program description contained in the summary support of the GHAA demonstration project, "a key to the success of the Alcohol Treatment Program is the cooperation and participation of the primary care physicians." The program summary continues by emphasizing that "it is essential that the physician's role and function be explicit and that the other modalities of care are available and known to him." That role may vary from simple identification and referral to actual patient counseling depending upon the philosophy and orientation of each health plan and medical director, but it is important that at least a physician advocate be designated to assume the primary support and educational role among the physician providers.

G. ESTABLISHING STAFFING AND FACILITY REQUIREMENTS

The type of staff selected for the alcoholism treatment program would be largely dependent upon the service delivery configuration that the plan selects. If the plan were to opt for a psychiatrically oriented program, the staff selected would reflect that choice. If the plans were to choose to contract for most alcoholism services, as does the Group Health Plan of St. Paul, Minnesota, it could hire a nonphysician alcoholism counselor with extensive experience to perform triage and liaison functions.

In some plans, staff are assigned from the mental health department on a rotating basis, or on the basis of skill and expressed interest in the field. Other programs use professionals with advanced degrees in social work (MSW's) and psychiatric nurses as well as psychiatrists and psychologists.

Physician involvement in the treatment of the alcoholic client could take two approaches:

- Using the physician to manage the medically related problems of alcoholic patients
- Using the physician in all aspects of treatment

Under the former arrangement, the physician familiar with the manifestations of alcoholism might be extremely effective in training other physicians to recognize the disease and associated medical problems; the latter approach would allow the physician to be involved in treatment of the alcoholism per se, by being a participant in long-term treatment to the extent he feels competent.

Professional staff should be hired according to the plan's standard criteria for psychiatrists, psychologists, and other professionals with special emphasis on their ability to adjust to the plan's treatment configurations and knowledge of alcoholism. In established plans a physician is necessary in the program for prescribing medication, monitoring progress, and making medical referrals.

The alcoholism field has long been marked by the involvement of nonphysician personnel. The best example of lay involvement is Alcoholics Anonymous (A. A.). A. A. is a fellowship of recovering alcoholics who meet to assist each other. The emphasis is on maintaining, with the help of fellow members, total abstinence. Plans might introduce their alcoholic members to A. A., Al-Anon, and Alateen as supportive mechanisms for the alcoholic members as well as for family members of both treated and untreated alcoholics. The prepaid plan might offer space in their facilities for meetings in addition to other alcoholism treatment services.

Alcoholism workers, including recovering alcoholics (with or without advanced degrees), could be selected on the basis of a number of criteria. The following criteria might be used for paraprofessional counselors:

- Successful completion of a major training course on alcoholism
- At least 18 months of clinical experience after training, including the evaluation and counseling of alcoholics and their relatives and experience in group, individual, and family treatment methods
- One year of clinical experience in a closely supervised setting
- Eighteen months prior experience dealing directly with a variety of medical professionals in inpatient and outpatient health care settings
- Familiarity with alcoholism agencies and treatment facilities within the community
- Proven capacity to assess patients with regard to detoxification needs
- If the applicant is an alcoholic, at least two years of uninterrupted sobriety to the present

H. DEVELOPING A PROVIDER AND STAFF TRAINING PROGRAM

Training programs for the treatment and referral of alcoholics should be implemented for the plan's health care delivery staff, particularly for primary care providers.

A plan has several options in determining the leadership and responsibility for training and educational needs. In a setting such as the Harvard Community Health Plan, the mental health component assumes the lead in provider education for substance abuse. In plans such as that at Harvard, medical school involvement is possible. Additionally, in other health plans, the utilization of existing community mental health centers and/or alcoholism treatment program staff might be more appropriate. It might be possible to use personnel from State Alcoholism Authorities and local alcoholism planning and coordination agencies for this purpose as well. When considering the utilization of outside personnel, however, the plan should assess the capability of such individuals to provide adequate in-service training in a manner acceptable to plan personnel.

The experience of existing prepaid plans demonstrates that involvement of physicians in substance abuse prevention programs is an important consideration. For example, continuing education programs for the medical staff should be incorporated into the program. Experience has shown that medical staff behavior and attitude change require the commitment of another physician to spearhead involvement in prevention, case findings, triage, and treatment of alcoholics.

The Arizona Health Plan supports a physician who works with the alcoholism program part-time and works with providers in a specialty (family medicine) during the work week. He is able to enhance provider understanding of alcoholism treatment and ensure the program's acceptance as an important component of the prepaid plan's overall health program.

Several prepaid plans report good results from using staff counselors to train physicians. Kaiser-Portland is developing its own videotape program for providers. Similarly, Kaiser-Southern California videotapes lectures it considers informative and makes them available to the staff of its six clincs.

All members of the plan's staff could be trained to participate in the referral process. Treatment personnel such as physicians, nurses, social workers, and mental health workers come into contact with alcoholics in the course of their daily work. One critical area to target is emergency room personnel. Other staff members, however, could be alerted to signs of the disease and could be trained to report symptoms of alcoholism to the program staff. For example, receptionists, administrative assistants, and appointment clerks, come into contact with members in waiting rooms and through other communications, and might be trained to recognize problems not overtly exhibited in examination rooms.

Kaiser-Southern California conducts one-day workshops for its supervisors to show them how to handle alcoholism problems within the plan's work force. Similarly, the Group Health Plan of Minnesota intends to institute small group training sessions with films, literature, and handouts to stimulate discussion.

I. DEVELOPING A CONSUMER EDUCATION PROGRAM

Education of Purchasers

The prepaid plan should mount an educational program about the benefits for employers, unions, and other consumers. General education should be geared to those employers already enrolled in the prepaid plan as well as any potential employer members. Employers should be taught the effects of alcoholism on employee effectiveness, absenteeism, and on-the-job safety. Employer training should result in increased knowledge and understanding of the alcoholic. Training would also illustrate the social and economic impact of alcoholism on business and industry. Because emphasis on the broader health problems would produce a more favorable attitude, alcoholism could best be included within the framework of a total organizational health care benefit package.

It is useful for HMO treatment program officials to contact Employee Assistance Programs in large enrollee groups to minimize misunderstandings. One misunderstanding between employee alcoholism programs and HMOs as noted by GHAA consultants and staff during the technical assistance portion of the NIAAA/GHAA contract was the HMO's emphasis on outpatient modalities and the preference of EAP personnel for residential treatment.

Education of Consumers

Alcoholism treatment has been introduced to plan members through informal discussion groups (open to all interested persons), fliers mailed to the membership, the display of posters, and newsletters. More structured education programs could be considered through the plan's health education program. Other educational techniques might include:

- Identification of high-risk groups for multiphasic screening, health assessment programs, and development of special programs for these groups

- Community outreach to attract members who are at risk but do not use the prepaid plan
- Coordination with community alcoholism education programs such as State Alcoholism Authorities, hot lines, and coordinating councils
- Special education programs in adolescent medicine, pediatrics, or internal or community medicine
- Confidentiality regarding members' use of alcoholism treatment services

Fliers and brochures are available from the National Clearinghouse for Alcohol Information, local chapters of the National Council on Alcoholism, the Jaycees, and other organizations.

The use of Alcoholics Anonymous and the staff of the HMO's own alcoholism program along with other providers for talks and lectures are an invaluable resource. Kaiser-Fontana uses a group of their own former patients as a "graduate group" to provide factual and inspirational help.

Vulnerable segments of the enrolled population need to be targeted for alcohol and other substance abuse education programs. One group critical to HMO preventive activities are adolescents. The HMO can supplement alcohol and drug education that is part of school curricula.

Pregnant women, minority or ethnic groups and other segments of the enrolled population could be especially targeted. The effectiveness of these education programs depends on the cooperation of providers in pediatrics, family practice and OB/GYN for many of these targeted efforts.

Many prepaid plans are examining the feasibility or have established occupational programs for their health plan membership. The Rhode Island Group Health Association Employee Assistance Program is a notable example of an in-plan, comprehensive program of early identification and treatment which has involved both labor and management in the successful identification and treatment of troubled employees.

The advisability or scope of an in-house occupational program would depend on a wide variety of factors, such as health plan size and available resources, integration of services with other behavioral problems, existing occupational programs within the community and major employer sites, and the attitude of unions and management concerning what constitutes quality, comprehensive alcoholism services.

J. DEVELOPING THE IDENTIFICATION AND REFERRAL SYSTEM

An important aspect of the HMO's preventive orientation is early intervention or secondary prevention. The identification and referral system should include specific written procedures for the identification and referral of members who are in need of treatment for alcohol abuse or alcoholism.

HMO providers as well as out-of-plan resources could make referrals to alcoholism programs. Such referrals could be made by telephone, written referral, or walk-in introduction. All three contact options should be available. Members needing immediate attention would benefit from having a means of immediate access through walk-in self-referral. The prepaid plan should decide the feasibility of allowing patient walk-ins and the times providers can be on call. The plan, however, must be alert to alcoholic persons using the facilities inappropriately. An alcoholism coordinator could assume the responsibility for monitoring the utilization of the facilites by walk-in patients, and could promote appropriate plan usage.

Other methods of referral which have been utilized in organizations similar to prepaid health plans include:

- Emergency room triage with a program staff member screening emergency room patients for alcohol-related problems
- Computer search of medical records to detect symptomatic patterns suggesting alcohol-related problems
- Health assessment programs which identify potential alcohol problems. These programs include automated histories and risk factor assessment and batteries of physical and laboratory measurement. Many of health assessment programs, both HMO based and worksite based, include screening for potential

alcohol problems. New enrollees are encouraged to use this service.

- Hospital admission review of all patients; when a chart notes an alcohol-related primary or secondary diagnosis or suggests alcoholism involvement, the program follows up with an in-hospital visit to the patient
- Medical record review of clinical histories for indications of alcoholism

Patient flow through the various referral points might be reduced to a simple chart form and made available to both providers and consumers.

K. DETERMINING PREMIUM LEVELS

Until recently, federally qualified HMOs were required to price all basic and prepaid supplemental benefits under a community rate (i.e., essentially the same premium for all contracts of similar family size). Under the 1981 amendments, community rating by class is allowed in which factors such as age and sex composition of a group can affect premiums charged.

The GHAA demonstration project offers some precedent for determining the marginal or additional costs of adding a comprehensive alcoholism program to existing health services offered by the health plan that is a component of premiums charged. The per member per month marginal costs ranged from 6 to 39 cents at each of the study sites, depending upon the size of the membership, the staffing pattern, and the organization of services. In 1980, the Minnesota actuarial estimate for an alcohol-drug treatment program, which included state-mandated residential care, was $1.00 per month for a family contract (or approximately 1% of premiums). This benefit would be supplemental in other states where residential treatment was not mandated. Aside from the provision of direct treatment services, these costs also included the study of patient functioning outcomes and pre/post health care utilization patterns. An important consideration is to determine what portion of the utilization would be handled by the following mechanisms, coming from the service delivery configuration:

- Use of existing plan resources
- New plan resources
- Contracted services
- Referral to noncontracted services

The three last mechanisms would have an additional cost to the plan attached to them so that pure premium would be calculated for each service. Pure premium is essentially an estimation of service costs per member. To the pure premium must be added a loading factor for the cost of administration, possibly an allowance for contingency, and possibly a factor for surplus for improvement of services. The loading factor is highly variable and would depend on statutory reserve requirements in the state insurance laws, administrative overhead, long-term debt service, the accounting conventions used, the competitiveness of the premium in the community, and legal reserve requirements. Contingency factors for inflation should be included in premium loading.

Several health plans have developed formulas for estimating demand. For example, the Harvard Community Health Plan has used the following formula:

- Ten percent of the population fifteen and older is alcoholic
- Eighty-one percent of the plan's membership is over fifteen, making 8.1 percent of the total membership alcoholic
- One-third of the 8.1% will become known, equalling 2.7 percent of the total membership
- One-third of the known alcoholics--equal to .09 percent of the total membership (round to one percent)--will be willing to accept treatment

To estimate the number of members likely to need detoxification, it was assumed that 20 percent of the known and willing to accept treatment alcoholics would need this service, equal to .2 percent of the HMO membership.

The Arizona Health Plan has used the following formula:

- 30,000 people belong the the Plan
- 80 percent of them are between the ages of 15 and 65, the period of high risk; therefore, there are 24,000 members at risk
- 5 percent of them, equal to 1,200 persons, will suffer clinical evidence of alcoholism according to NIAAA criteria

The development of such formulas would be integral to cost estimating. Prevalence, however, is less precise a measure or cost factor than actual utilization, which the GHAA demonstration project has found to be less than one per cent of total health plan membership.

Contracted services offer interesting possibilities for cost finding. In this case it might be possible to have outside providers share the risk by purchasing services on a capitation basis rather than on a fee-for-service basis. The risk-sharing method is used by the Medcenter Health Plan mentioned earlier.

Cost sharing, such as copayment or coinsurance (for non-federally qualified plans), has an effect on premiums for prepaid supplemental benefits. The cost of collecting copayments must be weighed against revenues generated. It would be possible to use both coinsurance and deductibles (for non-federally qualified) to offset service costs. For example, a schedule might be established for outpatient services whereby the plan would underwrite the full cost of the first five visits, charge a $2 copayment for the next five, charge a $5 copayment for the next five, charge a $10 copayment for the next five, and so on. Thus, initial entry to treatment would not have out-of-pocket costs as a barrier, long-term dependency would be discouraged, and the plan would recover some of its costs. Another example would be a $50 copayment for detoxification per episode.

Finally, the plan must consider the overall effects of its services on members. It might be inequitable to provide a member detoxification as part of a basic premium and then have the member rely on his or her own resources for further treatment. Because alcoholism is a "hidden disease," financing strategies might severely affect the ability to treat those with the disease and might curtail continuity of care.

L. MARKETING ALCOHOLISM BENEFITS

Although it is true that alcoholism benefits have been underused in HMOs as well as in other insured programs for employed groups, some normal caution must be used to guard against adverse selection when offering comprehensive alcoholism benefits. Caution is particularly important where residential care is covered as a supplemental benefit. When federal employees were covered for alcoholism by Aetna the aggregate and per capita costs were negligible but costs per case were distorted by a few high cost cases and providers.

Prepaid health plans, such as Providence Health Centers, Inc., of Providence, Rhode Island, have found that marketing the alcoholism treatment services has had a positive impact on their efforts to enroll employee groups for general coverage. Having an alcoholism program in place might heighten the competitive position of HMOs in relation to other health insurance policies. One factor that would be important is whether enrollee groups have access to alcoholism outreach and treatment programs through their employers, unions, or other means. One consideration, if such exists, would be whether they could be coordinated with the prepaid plan. Another factor is whether vigorous marketing of alcoholism benefits would lead to disproportionate enrollment of alcoholics who, particularly before treatment, are higher than average utilizers of services. In a competitive environment such adverse selection must be considered.

In general, the marketing effort should be initiated about six months before initiating services. The actual preoperational sales period through initial membership would take approximately three months and be devoted to educating and gaining employer and individual member acceptance. The bulk of this effort would entail the following activities:

- Orientation of sales personnel
- Detailed development of sales strategies
- Establishment and implementation of the key employer strategy review group
- Preparation and production of sales and marketing material such as:
  - Booklets
  - Video tape presentation
  - Tables illustrating incidence and prevalence of use and abuse of alcohol

The numbers and type of personnel required for this effort would depend on size and capabilities of the existing prepaid plan's marketing staff.

A marketing spokesperson from the Arizona Health Plan suggested that the emphasis should be on mailing literature to all potential accounts outlining the "cost and people benefits of having an alcoholism program available." When an employer, government agency or union shows interest, the marketing staff could offer assistance in establishing a working "alcoholism program" in their organization. A consideration in establishing liaison with employer and union groups would be that not all members of the groups would necessarily be plan members. They might have other forms of health insurance or none at all.

Recognizing that extreme variations exist between metropolitan areas, the prepaid plan personnel should approach key members of existing alcoholism and employee assistance resources to discuss the prospective program, its probable impact on the community at large, and its potential reception by local treatment personnel.

If the prepaid plan were to develop contractual relationships, it would be important that contractors as well as referral sources understand the objectives and operations of the prepaid health plan. For example, the staff of the Rhode Island Group Health Association, Inc. (RIGHA) recently evaluated 40 local programs for referral consideration. Unlike many other programs, RIGHA does provide most services in-house, occasionally using an outside facility. The RIGHA alcoholism program administrator pointed out the possibility of friction between the medically oriented plan employees and the social model orientation of some community programs.

Another consideration in marketing is the perception that if an alcoholism program were to be developed and marketed, it would be inundated by patients seeking to enroll. There is no evidence to support this belief; in fact, the converse is generally true. It takes considerable time to develop the clientele. Again, the GHAA demonstration project has found that less than one percent of the total health plan membership sought treatment during any given year.

M. LICENSING AND ACCREDITATION

Licensing requirements for alcoholism programs within HMOs vary by state. Licensure requirements apply more stringently to those prepaid group plans that offer inpatient detoxification or residential treatment in-plan. Checking with local health departments would reveal what, if any, requirements must be met.

A plan should consider accreditation by the Joint Commission on Accreditation of Hospitals. The JCAH has indicated that its accreditation program for alcoholism programs is voluntary, but in some states third-party payors such as Blue Cross insist that programs be accredited or eligible for accreditation before they can be reimbursed for services. This is an increasing trend among third-party payors, and one which the plan might want to consider a prerequisite for those external resources from which the plan might purchase services.

The alcoholism treatment program seeking accreditation need not meet the standards established by the JCAH for other types of psychiatric facilities. It need only comply with those standards developed specifically for alcoholism programs.

III. SELECTION OF APPROPRIATE TREATMENT MODALITIES

There are varying modalities which may be utilized in alcoholism treatment. Based on the GHAA demonstration grant which examined the feasibility of providing alcoholism services within the HMO setting, the predominant modality at each of the study sites was almost exclusively outpatient care, supported by emergency and follow-up services. The prepaid plan should select the appropriate modality(ies) after determining the needs of its target population and deciding its capability to provide for these needs within the constraints of cost-effectiveness. The HMO with its incentives to conserve resources can evolve more effective mixes of treatment modalities. Besides use of outpatient services, HMOs can use recovering alcoholics in both treatment and education which has been proven to be effective at Kaiser-Fontana and other programs.

A. DETOXIFICATION AND EMERGENCY CARE

These services provide immediate evaluation and care for members who may be acutely intoxicated, who may be in need of immediate medical attention, or who may require emergency assistance for psychiatric or social problems related to alcohol use. Prepaid plans provide walk-in treatment and emergency services for all enrolled patients. To provide effective emergency treatment for the alcoholic patient, program planners should ensure the following:

- Staff should be trained to recognize and respond to alcohol related emergencies

- Referral systems should be designed so that alcoholism treatment staff are brought into contact with the member seeking emergency care as soon as possible (see the attached Programmatic Update Appendix for information on the Health Alliance Plan's automatic referral system).

Detoxification, though required by only a small minority of patients in the GHAA study, can be achieved simply, inexpensively, and efficiently, and need not require inpatient care. Moreover, a majority of the persons admitted to an alcoholic treatment center do not need medical treatment requiring hospitalization, and of those who do require hospitalization, a large number can be medically stabilized within a brief period, usually 48 to 72 hours. With the adjunct of A.A., many patients are also now being detoxified on an outpatient basis. The Kaiser Fontana program uses two types of withdrawal treatment, "major" and "minor." (See the Programmatic Update for further information).

Once those patients in need of inpatient detoxification or other emergency medical services have been treated, they can receive counseling or other therapeutic services on an outpatient basis for considerably less cost.

B. INPATIENT SERVICES

These services should be provided to those persons suffering from alcohol-related illness or who are not psychiatrically stable at the initiation of alcoholism treatment. A wide range of medical and psychosocial treatment may be initiated, including but not limited to:

- Individual, family, and group therapy
- Chemotherapy
- Counseling
- Alcoholics Anonymous activities
- Occupational and recreational activities

Inpatient care under basic HMO benefits is almost always for the treatment of medical complications of alcoholism or alcohol abuse.

Inpatient care is utilized only when indicated by the physical and emotional condition of the individual, and when alternative, less intensive services are not appropriate. Extensive treatment services may be rendered in a general hospital or in a specialized alcoholism treatment facility.

C. INTERMEDIATE CARE SERVICES

Most persons in the health care field associate intermediate care with nursing homes. In alcoholism treatment the term intermediate care has a particular meaning. These services should be oriented to those patients not requiring intensive inpatient care but in need of day or night care, and/or sheltered living arrangements including social or vocational services; psychosocial modalities are stressed in such a service. Intermediate care is provided in settings such as:

- Special alcoholism hospitals
- Halfway houses
- Quarterway houses

These services are not usually covered under basic HMO benefits. They are covered, however, in those states where residential care is mandated for group insurance or when more extensive services are offered under supplemental benefits.

The prepaid plan will generally contract out for these services and will not generally assume the costs under the basic benefit. Under supplemental alcoholism or extended care benefits, however, the prepaid plan may assume the risk and develop a premium add-on. In this case, it will be incumbent on the plan to select intermediate care services that are acceptable to enrollees and providers. Often only a few employers will buy these benefits and the characteristics of the population with the benefit must be considered.

D. OUTPATIENT SERVICES

When inpatient services are not necessary or appropriate, outpatient services are used to provide the range of treatment specified in the previous section. Part of the total outpatient care is assistance with jobs, housing, or legal problems.

These services may be provided in-plan within a free standing, mental health, social services or other department. Services may be provided by outside organizations such as alcoholism treatment centers, community mental health centers, or other community health and social services agencies, by contractual agreement. When providing these services, the plan should make evening hours of treatment available so that working individuals may maintain their normal schedules.

For further information on the refinement of outpatient treatment to serve specific populations, see the Programmatic Update, particularly the section on the Arizona Health Plan.

E. RESIDENTIAL TREATMENT

Treatment in a residential setting should be arranged for those patients who require long-term care in specialized facilities for this purpose. This modality would be unlikely to be offered by an HMO but referrals might be made. This environment provides the patients with supports which cannot be provided by the prepaid plan such as:

- Housing
- Companionship
- Group incentive and support

When selecting a residential facility for referral, plan staff should select facilities with a range of medical, vocational, mental health, and social services as well as residential accommodations. Any plan member referred for this type of care can be seen in the outpatient program after completion of residential treatment, and after the patient's condition has stabilized. It is important that communication be maintained between the plan and the residential treatment program, including ongoing program monitoring and notations of patient progress in the medical record.

F. FOLLOW-UP AND AFTERCARE SERVICES

Following discharge or dropout from the alcoholism treatment program, follow-up services should maintain periodic contact with the client for a specified period of time. Social work, marketing, health education and health assessment personnel all have a role in developing preventive and outreach efforts. In many programs, including those based in HMO settings, former patients are periodically seen as individuals or in groups to maintain contact with treatment personnel or sober peer groups as well as an adjunct to treatment of current patients.

Alcoholism treatment program administrators should stress the continuing availability of services prior to patient discharge or to patients who have postdischarge problems, complications, or relapses. These services may be provided either by the plan or by contractual arrangements with outside resources.

G. OUTREACH SERVICES AND PREVENTION

In most cases, outreach and prevention activities related to alcoholism can be integrated into the general program of the prepaid plan's outreach, educational, screening, and preventive efforts. Questions to elicit pathological drinking should be included on health screening batteries. Often these are taken from standard tests such as the Michigan Alcoholism Screening Test (MAST). Most frequently self-reported problems of alcohol abuse are elicited.

H. EDUCATION

The prepaid plan should provide information to its enrollees and patients regarding the nature of alcoholism and its treatment. Alcoholism needs to be a topic in any program of continuing provider and staff education. In the Arizona Health Plan, provider education has resulted in referrals to the Alcoholism Dependency unit at earlier stages. Provider education is available from the AMA, A.A. General Services, the National Council on Alcoholism, etc. An HMO may use tapes, lectures, and case conferences. It is important that not only primary care providers but also specialists, nursing staff and receptionists be exposed to alcohol education. Particularly important is the sensitization and education of emergency room staff.

Patient education is often part of the HMO services. Most HMOs prepare lectures, slides, tapes, and other audiovisuals. In addition, a mainstay in HMO preventive services is courses on such subjects as CPR, nutrition, and exercise. A prominent part of this activity is alcoholism education including alcohol as it affects adolescents, women and other enrollee groups. Hot lines, brochures and inventories of community resources are also part of many HMO educational services. Again, alcohol is an important focus of these services. Curricula for patient education are available from a variety of sources, including state alcoholism authorities, universities and councils on alcoholism.

IV. PROGRAM MONITORING AND EVALUATION

The planning, development, and monitoring of the alcoholism treatment program should be an ongoing process if the program is to achieve its objectives and meet the challenges of the changing field of health care.

A. MONITORING THE ATTAINMENT OF TREATMENT OBJECTIVES

During the initial planning and subsequent implementation phases of an alcoholism treatment program, administrators must assess the relevancy of the objectives in relation to client needs, or whether the client's defined needs coordinate with the treatment objectives. Other areas to be monitored and evaluated would be:

- The feasibility of treatment objectives within the plan's financial constraints
- Support of treatment objectives by specific written guidelines and policies so that their implementation is realistic within the program's physical set-up and staffing patterns
- Whether the treatment objectives assure that the client is treated with respect and integrity

One instrument that, if properly modified, could be used to measure treatment effectiveness is the Patient Assessment Form (or PAF) used by GHAA in evaluating its demonstration sites. This is available from GHAA or NIAAA.

Alcoholism treatment should also be built into an HMO's quality assurance program. Quality assurance programs are required for federally qualified HMOs and procedures have to meet the standards of the National Commission on Quality Assurance.

B. MEASURING COSTS AND BENEFITS

Program costs during any given time period should reflect the cost of all personnel, supplies, overhead, and organizational resources incurred organizing and delivering program services.

Such costs could be accumulated through the HMO's accounting system. Programmatic benefits, on the other hand, while simple to conceptualize, are in many instances difficult to measure. Essentially, benefits are the reverse side of the economic costs of alcoholism within the plan's membership. Any reduction in the costs of alcoholism-related impairments leading to a normally productive, healthy life style would represent an accrued benefit of program efforts aimed at rehabilitation and treatment. An important area of cost savings for a prepaid plan would be a reduction of medical care needs normally associated with the pathological disorders which accompany alcoholism such as pancreatitis, fatty liver, hypertension, obesity, cirrhosis, as well as a range of psychological problems such as anxiety, depression, and nervous disorders. Wersinger, et al found significantly higher utilization rates for alcoholic patients within the HMO setting (Genesee Valley Group Health Association) both for ambulatory (23% higher) and inpatient (12 times greater) visits as compared to matched controls.[1] Thus, untreated alcoholics are high users of care.

Treatment of alcoholism might eliminate many such problems, thereby reducing utilization of other services and ultimately reducing individuals' and employers' medical insurance costs.

The GHAA demonstration project, for instance, found not only a reduction in the rate of utilization of health plan services by alcoholics and family members 18 months following treatment intake, but also a dramatic change in the type of utilization, including a reduction in emergency visits from 31% to 9% of all encounters, an increase in scheduled visits from 59% to 71%, and a reduction in physician encounters from nearly 70% to 51%. In another pre/post medical service utilization study comparing alcoholics who participated in treatment versus those who did not, Sherman, et al at Kaiser-South found that the participating group incurred a decrease in total costs of $13 per patient year, while the non-participating group experienced increased costs of $305 per year. Sandra Putnam also found reductions in use of health services by an alcoholic population compared to those who did not present for treatment.

In terms of employers, cost savings are easily identified, the greatest being reduction in absenteeism. Absences probably constitute the single largest cost of on-the-job alcohol abuse and alcoholism. Changes in absenteeism are the most easily measured and "costed-out" benefits of treatment to the employer and, therefore, would provide a solid basis for measuring program benefits. As an illustration, the GHAA alcoholic study population demonstrated a 55% reduction in the rate of absenteeism, and a 90% reduction in reprimands at work through the first 18 months following entry into treatment.

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[1] Wersinger, R., Roberts, J., Roghmann K., and Wells, S., "The Inpatient Hospital & Ambulatory Utilization Experience of an Alcoholic Population Compared to a Matched Control Group Within an HMO," Presented at the Group Health Institute, 1978.

In addition to reductions in absenteeism, there could be numerous areas of identifiable, potential benefits to the employer such as:

- Reduction of on-the-job accidents connected with alcoholism
- Reduced waste and equipment damage
- Reduction in utilization of medical services resulting from accidents
- Reduction of labor turnover costs
- Reduction in expenditures to recruit or replace, and train workers

If the prepaid plan chooses to assess costs and benefits of alcoholism programs, it would be beneficial to gain the support of enrollee groups and labor unions, because the collection of these data might be perceived as an encroachment on labor and management prerogatives.

C. USING MONITORING AND EVALUATION DATA TO CONTINUE PROGRAM PLANNING AND MANAGEMENT

Issues in program planning that result from program monitoring and evaluation are those that relate both to efficiency and quality of care. A number of mechanisms and techniques are available for quality assessment of treatment programs which allows for redefinition and restructuring of existing services.

Information should be gathered from groups such as:

- External peer review committees
- In-house peer review committees
- Standardized comparative data systems
- Longitudinal studies of patients
- Cost-benefit analysis prepared by the plan for specific diseases or patient categories

Some guideline measures used for program evaluation in alcoholism activities could include:

- Number of patients treated compared with estimates of the total number of alcoholics in the prepaid plan population
- Cost per case of alcoholic patients compared to other illnesses in the plan
- Medical utilization of alcoholic patients before and after treatment
- Disenrollment of alcoholic enrollees compared to averages for the plan
- Assessment of outcomes in terms of the following:
    - Sober days before and after treatment

- Functioning in society
- Health status

Such information is useful for meeting the goals of the HMO and ultimately for promoting more effective care for alcoholics not only in the HMO but wherever health care is rendered.

APPENDIX A

EMPLOYER-RELATED MATERIALS

SUGGESTED COVER LETTER SENT TO EMPLOYEES*

Dear Fellow Employee and Family:

The XYZ Company recognizes there may be employees and members of their families who have problems which effect work performance. While the company does not wish to interfere in any way with the private lives of its employees, it does recognize its responsibility to assist employees in finding help when needed.

As you may have read in recent magazines and local newspapers, the Employee Assistance Program of the Rhode Island Group Health Association is rapidly becoming known as the most comprehensive employee counseling service in Rhode Island. This program has provided professional counseling to more than 1700 employees in the last three years for problems ranging from abuse of alcohol and other drugs, marital and emotional difficulties. It is a comprehensive professional counseling program for every employee who needs assistance to keep problems from affecting the way he or she works.

The enclosed booklet describes what EAP is and what it has to offer. The program emphasizes strict confidentiality, emphasis on family involvement and minimal cost.

We would hope that those who believe they need help will avail themselves of this valuable service.

Very truly yours,

Enclosure

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* Rhode Island Group Health Association.

APPENDIX A(2)

COMPANY COST ANALYSIS*

1. ____________________ x 7.5% = ____________________
   Total # of employees x Probable # of employees with alcohol probs.

   It is estimated that 5-10 percent of the nation's work force suffers from some form of alcohol abuse.

2. ____________________ x ____________________ = $ ____________________
   Average yearly income x Cost efficiency reduction = Loss per alcoholic employee per year

   The highest executive is as likely to develop a drinking problem as the lowest paid laborer. Therefore, it is important to average the yearly income of all employees. The cost efficiency reduction figure is based on research that indicates that an employee's alcohol problem will cost the employer an average of 24.8 percent of his yearly income. This loss results from lower productivity, bad decisions, absenteeism, on-the-job accidents, wasted material, cost of grievance procedures, and decreased job performance in general.

3. ____________________ x ____________________ = ____________________
   Loss per alcoholic employee per year x Probable # of alcoholic employees = Total estimated loss per year

4. ____________________ x ____________________ = $ ____________________
   Recovery rate average x Total estimated loss per year = Estimated cost reduction per year

   Research indicates that 50-80 percent of the alcoholic employees identified under an early identification program will recover and bring job performance back to normal.

   Data provided by: National Institute of Alcohol Abuse and Alcoholism

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* N. B. Alcohol accounts for over 50 percent of the problems occurring among employees and has been the subject of considerable research. For this reason this particular problem is highlighted below.

APPENDIX A(3)

FACTS ON ALCOHOLISM IN INDUSTRY

1. The alcoholic employee is absent 2 to 4 times as often as the non-alcoholic employee.

2. On-the-job accidents for alcoholic employees are 2 to 4 times more frequent than among nonalcoholic employees. Off-the-job accidents are 4 to 6 times as numerous.

3. Sickness and accident benefits paid out for alcoholic employees are 3 times greater than for the average nonalcoholic employee.

4. In one auto assembly plant out of 746 grievances filed during one year, 363 were alcohol-related (48.6%).

5. In another one year study of 50 alcoholic employees, it was found that grievances filed were 4 times the average of nonalcoholic control group.

SOME PROGRAM RESULTS

1. Over a two-year period a mining company has reduced absenteeism among 150 referred alcoholics by 52%.

2. One division of an auto manufacturer reports that during a one-year period grievances among 117 referred alcoholic employees dropped from 41 to 9, a decrease of 78%.

3. A large communications company has reduced on-duty accidents by 81% (57 to 11) and off-duty accidents by 63% (75 to 28) among 402 referred alcoholics (5 years before and after program participation).

4. A public utilities company has had an alcoholism program since 1947. During this time, not one alcohol-related grievance has gone to arbitration.

5. The average rehabilitation rate among 16 different alcoholism programs has been 74.8%. (The recovery rate among jobless alcoholics is only 25%.)

6. A recent study of the economic effects of alcohol-related problems estimated that in 1971 these problems cost U.S. society over $25 billion. Of this, $9.35 billion related to lost production of goods and services and another $8.29 billion resulted from medical care expenses. (Second Special Report to Congress on Alcohol & Health).

7. Some estimates are that each employee with a drinking problem costs the firm $2,500 each year, given an average annual wage of $10,000.

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* Rhode Island Group Health Association.

[illegible]

[illegible]

[illegible]

[illegible]

APPENDIX B

SAMPLE NEEDS ASSESSMENT SURVEY
(For County Alcoholism Agencies)

A needs assessment survey provides a rational framework for the county alcoholism plan. The Advisory Committee can apply this outline to determine where the alcoholic population is likely to be found.

BACKGROUND INFORMATION

List the types of industry, transportation systems, population characteristics (both income and ethnic), and any other factors having a significant effect on the life style of the citizens of the county.

INDICATORS OF NEED

Against the background information gathered above, study the indicators of need below. These are not certain indicators of alcoholism, but areas with high unemployment, etc., and can be considered fairly probable locations of high levels of alcohol abuse.

1. Consult the county health officer on the Jellinek Formula, which estimates the number of alcoholics in the county by the rate of deaths from cirrhosis.

2. Public Assistance Rate -- 15 to 30 percent of all clients on public assistance are probably alcoholics.

3. Admission rates to hospitals and mental health facilities: 20 to 40 percent of all patients admitted to county hospitals and medical facilities are estimated to be alcohol abusers.

4. Criminal Justice -- at least one-half of all prisoners are incarcerated for alcohol-related offenses. Estimates for some jails are as high as 80 percent. People arrested for public inebriation can all be counted as alcohol abusers.

5. Highways -- 50 percent of auto and pedestrian accidents involve alcohol abuse.

6. Alcohol Consumption Rate -- the state alcohol authority may be able to provide average annual per capita alcohol consumption figures for your county. The national average is 2.61 gallons annually.

7. Per Capita Income -- it is generally assumed that as income increases, opportunities for private alcoholism treatment also increase. Therefore, the need for county alcoholism treatment would seem to be most acute in areas with the lowest per capita income.

8. Unemployment Rate -- high unemployment leads to increased abuse of alcohol for some; joblessness is demoralizing, and some become dependent on alcohol for a "lift." Areas with high unemployment rates can be expected to need alcoholism treatment services.

9. Housing Patterns -- single-room occupancy buildings in fair to good condition occupied by a long-term lower-income population revealed a high level of alcoholism. The percentage of alcoholic persons in some buildings reportedly is as high as 50 percent.

10. Ethnic Groups -- certain ethnic groups such as American Indians and the Irish are identified as having special alcohol-abuse problems. Large concentrations of these ethnic groups would indicate special programming needs.

11. Industry -- survey local businesses, especially those with occupational alcoholism programs to determine the extent of employee alcohol abuse.

12. Health Insurors -- if local health insurors cover alcoholism treatment, obtain the number and characteristics of persons treated. If not, ask for figures on alcohol-related illnesses, such as cirrhosis.

Putting this information together, the Advisory Committee will have a picture of the county, showing where alcoholics in need of treatment will likely be found. It will be an estimate, and a rough one. However, it is a starting place, and, as the program develops, data-gathering will become an important component in planning.

APPENDIX C:

GUIDELINES FOR ALCOHOLISM: DIAGNOSIS, TREATMENT AND REFERRAL*

GUIDELINES	EXPLANATORY NOTES
I. For All Physicians With Clinical Responsibility: Diagnosis and Referral	
A. Recognize as early as possible alcohol-caused dysfunction in the biological, psychological and social areas.	A. AMA Manual on Alcoholism; Diagnostic and Statistical Manual III, American Psychiatric Association, 1979; Criteria for the Diagnosis of Alcoholism (American Journal of Psychiatry Vol. 129, No. 2, 127-135 (August), 1972 or Annals of Internal Medicine, Vol. 77: 249-258 (August), 1972); and "Definition of Alcoholism," Mark Keller, in Quarterly Journal of Studies on Alcohol Vol. 21: 125-134 (March), 1960.
B. Be aware of those medical complications as well as symptoms and syndromes by which alcoholism is commonly presented.	B. (Medical Complications of Alcohol Abuse and Alcoholism, 1973); Chronic tension states, vague somatic complaints, depression, cardiovascular and gastrointestinal disorders.
C. Insure that any complete health examination includes an in-depth history of alcohol and other drug use.	C. Le Go Grid; MAST; "Alcoholism: The Physician's Role in Diagnosis and Treatment," in Family Practice, Knott et al (1973: Saunders), 265-75; and Knott, D. H., "Alcoholism: A Complex Clinical Syndrome" (Hospital Medicine) January 1979, Vol. 15: 50-65.
D. Evaluate patient requirements and community resources so that an adequate level of care can be prescribed with patient needs matched to appropriate resources.	D. Information usually available from county medical societies, local Council on Alcoholism, and state or local Divisions on Alcoholism and Drug Abuse.
E. If there are medical needs, including severe withdrawal, make referral to a resource that provides adequate medical care.	E. Another physician, hospital or alcoholism program featuring integrated medical services.

*As Adopted by the AMA Council on Scientific Affairs, October 8-9, 1979

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GUIDELINES	EXPLANATORY NOTES
II. For Physicians Accepting Limited Treatment Responsibility (To Restore the Individual Patient to the Point of Being Capable of Participating in a Long-Term Treatment Program)	
A. Assist the patient in achieving a state free of alcohol and other sedative-hypnotic drugs, including management of acute withdrawal syndrome, which is commonly referred to as detoxification.	A. Office, hospital or clinic may be used depending on patient's condition. (Principles and Practice of Emergency Medicine, Vol. II, Knott et al (1978: Saunders), 1345-1350.)
B. Recognize and treat or refer all associated or complicating illnesses.	B. Both physical and psychiatric conditions.
C. Apprise the patient of the nature of his disease and the requirements for recovery.	C. Discuss issues relating to onset, nature and course of illness, as well as prognosis, if treated or untreated.
D. Evaluate resources--physical health, economic, interpersonal and social--to the degree necessary to formulate an initial recovery plan.	
E. Determine the need for involving significant other persons in the initial recovery plan.	E. Determine clinical appropriateness, depending on ethical codes, state laws and HEW rules and regulations concerning confidentiality. Significant other persons may include families, (parents, sisters/brothers) and sexual partners, and employers.
F. Develop an initial long-term recovery plan in consideration of the above standards and with the patient's participation.	F. This long-term recovery plan would address those factors listed in the following section entitled "For Physicians Accepting Responsibility for Long-Term Treatment." At this point, the physician can assume the responsibilities delineated in the next section, or refer to another physician or long-term recovery program.

GUIDELINES	EXPLANATORY NOTES
III. For Physicians Accepting Responsibility for Long-Term Treatment	
A. Acquire knowledge, by training and/or experience, in the treatment of alcoholism.	A. Specialized programs: abstracts of scientific literature available from NIAAA, National Council on Alcoholism, American Society of Alcoholism, American Medical Association, appropriate journals on alcohol and alcoholism: visitation to alcoholism treatment centers and Alcoholics Anonymous.
B. The following responsibilities should be conducted or supervised by the physician:	
1. Establish a supportive, therapeutic and non-judgmental relationship with the patient.	1. This is the vehicle whereby the physician directs, supports and monitors the patient over a period of years. Attempt to modify patient's isolation, grief and guilt, and deal with other significant psychotherapeutic issues.
2. Within the confines of this relationship, establish specific conditions and limits under which the therapy will be conducted, and carefully explain them to the patient.	2. Physician and patient responsibilities should be clearly defined.
3. Periodically evaluate and update the recovery plan with the patient's participation.	3. Evaluation should be patient-oriented and include not only evaluation of patient's physical health but also psychosocial functioning.
4, Involve the patient with an abstinent peer group when appropriate.	4. At this point it is critical that referral to professionally guided or self-help groups, such as Alcoholics Anonymous, is specific and appropriate to the patient's needs.

APPENDIX C(4)

GUIDELINES	EXPLANATORY NOTES
B. The following responsibilities should be conducted or supervised by the physician:	
5. Become knowledgeable about and be able to utilize various health, social, vocational and spiritual support systems.	5. i.e., vocational rehabilitation, educational advancement, skills training, halfway and recovery houses, recreational facilities.
6. Evaluate directly or indirectly significant other persons and, unless clearly contraindicated, involve them in treatment.	6. Treatment may be provided by the physician, another professional, Al-Anon or a comprehensive treatment program.
• C. Continually monitor the patient's medication needs. After treatment of acute withdrawal, use psychoactive drugs only if there is a clear-cut and specific psychiatric indication in addition to alcoholism.	C. Schizophrenia or major affective disorders may be treated with psychoactive substances that are not ordinarily dependence producing or subject to abuse. However, special care should be exercised in the administration or prescribing of anti-anxiety agents, barbiturates and barbiturate-like drugs, and anti-depressants.
D. Be knowledgeable about the proper use of deterrent drugs.	D. Specifically, disulfiram (Antabuse) in this country.
E. Throughout the course of treatment, continually monitor and treat or refer for any complicating illness or relapse.	E. Check for organic and psychiatric complications, as well as for use of alcohol or other sedative-hypnotic drugs.
F. Be available to the patient as needed or for an indefinite period of recovery.	

APPENDIX D:

PROGRAMMATIC UPDATE

The following appendix updates the "Programmatic Descriptions" section of the December, 1978 Alcoholism Within Prepaid Group Practice HMOs report written by GHAA staff and mentioned repeatedly in the body of this handbook. The "Programmatic Descriptions" section contained descriptions of the Arizona Health Plan, the Health Alliance Plan and Kaiser Permanente Medical Care Program in Portland, Oregon. The description of the Kaiser Permanente Los Angeles Alcoholism Program, which appeared in the April, 1980 report, is also updated here.

Key personnel working directly with the alcoholism programs were contacted by GHAA staff to ascertain what changes have occurred over the past few years. The study site contacts were asked to address the following questions:

- Do you use more or less detoxification, inpatient treatment or outpatient treatment?
- Do you prescribe more or less antabuse?
- Have you hired more staff?
- Is the program more or less A. A. oriented?
- What innovations have occurred in treatment modalities?
- Has the budget increased or decreased?

The Kaiser Permanente facility in San Bernadino County of Southern California, commonly referred to as the Fontana unit, was also contacted by GHAA staff. The Physician-in-charge and the Chief

Counsellor were asked to describe the Alcohol and Drug Dependency Program. The Fontana unit was contacted to contrast it with the four project study sites.

Arizona Health Plan*

Organization of services is presently essentially the same as described in the December, 1978 report for the Arizona Health Plan's (AHP) Alcohol Dependency Department (ADD). Outpatient treatment is strongly emphasized.

Provider education of the general medical staff has contributed to a significantly lower rate of detoxification for the ADD program.

In general, the entire plan is more attuned to the program's importance. The increased awareness is due in part to Dr. Ross Landess's personality and credibility within the Arizona Health Plan as reflected by his presence as part-time Family Practice Physician. Dr. Landess served as a technical assistance consultant for the project as described in the Technical Assistance Follow-Up in Appendix E.

Providers have been more willing to listen and receive information because of him. Their receptive attitude is a change from the previous "I don't know and I don't want to know" disposition.

Physician extenders such as physician assistants and nurse practitioners are doing very well in diagnosing and referring patients, often more quickly than the physician themselves. The younger physicians are generally more willing to learn than the older, less flexible doctors.

More Antabuse is now being prescribed. In addition to increased primary provider awareness of the Antabuse modality, the large Chicano population in the Phoenix area has contributed to more of the drug being used. According to the ADD contact, many Chicanos maintain sobriety initially only while on Antabuse. There is very strong pressure in the Chicano socio-economic milieu to drink beer.

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* The ADD contact was Mike Larsen, Departmental Coordinator.

More therapists have been hired. Where there were originally only one or two therapists, there are now seven full-time social workers and one part-time Ph. D. psychologist.

The department manager, one of the social workers, is very A. A. oriented. The plan contact said that A. A. and Al-Anon are used as adjuncts to the therapy provided by ADD because everything in the literature and the program's experience shows that A. A. has kept people sober longer. The plan has an Al-Anon and an A. A. meeting in the building on Friday nights and the surrounding community is A. A. oriented.

Refinements of the original treatment modalities have entailed the creation of groups addressed to special problems of specific populations, including:

- married couples (to work on problems other than alcoholism);
- homosexuals;
- spouses of alcoholics (similar to Al-Anon);
- women alcoholics;
- Vietnam veterans;
- a group for assertiveness training; and
- teenagers (as the need arises).

The extensive expansion of services to special populations, as well as a substantial increase in the number of therapists, is indicative of the growing nature of the ADD program, the Arizona Health Plan, and of the surrounding "Sun Belt" area in general. ADD is extending services along with regionalization of the plan in general. Presently two therapists provide ADD services in the Western region (Maryvale & Glendale). Projected for mid-1982 are services for the Eastern region (Scottsdale & Tempe).

Health Alliance Plan*

Again, the organization of services and the philosophy of treatment have remained essentially the same as at the start of the study at the Health Alliance Plan (HAP) in Detroit. Some changes, have, however, ameliorated the quality of treatment.

According to Mrs. Schuman, the HAP contact, ninety-five percent of detoxification is being done on an outpatient basis. Many patients come from outside the plan and are already detoxified. Some patients are hospitalized and detoxified but this is not a significant number.

An automatic referral system was instituted at the beginning of 1980. The program no longer had to wait for physician referrals to begin treating alcoholics. All patients diagnosed as having gastritis, pancreatitis, liver disease, or alcoholism are referred automatically to the alcoholism program. Staff will check their past medical records to see if they have had a previous alcoholism record to further verify the alcoholism diagnosis. Physicians may still refer patients when alcoholism problems are not easily detectable. The HAP automatic referral system has worked very well and has significantly improved patient flow. It required some salesmanship to the physicians but this was facilitated by increased physician acceptance of the alcoholism staff as full members of the health team.

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* The HAP contacts were Zebedee Bishop, Department Head and Director, Joyce Cooper, Data Management Supervisor, and Sarah Schuman, Program Supervisor.

More inpatient referrals are also being received due to a provider attitude change. Provider education has led them to believe in the competency of alcoholism treatment. Seeing patients improve has been a significant factor in the change of attitude. The successful nature of HAP's program makes providers realize the program is accomplishing something, adding to the incentive to refer. Some negativism towards alcoholics occurs in the emergency room where only crisis patients are treated.

The prescription of drugs such as Antabuse and valium has been effected by provider education as well. More Antabuse is now prescribed and the alcoholism staff is asking for more of it and for physicians other than the program physician to prescribe the drug. Some monitoring of Antabuse in the alcoholism office is being done at the therapist's discretion. Also, valium is being prescribed less by physicians at HAP for the treatment of withdrawal.

One half-time therapist has resigned to take a position elsewhere and this job has subsequently been abolished due to budget cuts caused by economic hardship in Detroit. The secretary of the program has expanded her job by seeing inpatients and doing bedside, educational and motivational therapy.

Numerous referrals are being made to A. A. on a more systematic basis than in previous years. Two A. A. meetings are still being held on the premises but the staff is also concentrating on referring more patients to meetings in their own neighborhoods. Alcoholics Anonymous is used in conjunction with lecture, group therapy and appointments as a method of outpatient detoxification.

An interesting idea for the future is the potential development of a "Women for Sobriety" group as an alternative to A. A. for female alcoholics. The group would be based upon a group initiated by Jean Kirkpatrick, Ph. D., who believed A. A. did not entirely serve the needs and the problems of women. A nutritionist has been added to the program who comes in once a week to address the effects of nutrition on sobriety, the effects of alcoholism on nutrition, nutrition and lifestyle, and so on. Another new facet of the program is the periodic presentation, by graduate students doing their internships in pharmacy at the hospital, of information on the use of Antabuse and the interaction of alcohol and prescription medication.

Costs, particularly for labor, have risen substantially in the last few years. Rather than cut staff, however, HAP has tried to cut other less essential items such as free literature. According to the HAP source, the alcoholism program, because of budget cuts, is lucky to have survived. Other departments have been shut down and physicians are being laid off. Many treatment programs in the Detroit metropolitan area have lost their funds and closed down. The overflow from these programs has been absorbed by HAP and other local programs still in existence causing an excessive waiting list at HAP. At one point, there were seventy-five people on the list. Mrs. Schuman speculated that there were only ten intakes out of those seventy-five. The other sixty-five probably returned to drinking after the crisis that had led them to be on the list had passed. She expressed hope that the program would be able to pick up these individuals the next time around.

Another example of the discouraging economic situation in the Detroit area, an effect of the layoffs in the auto industry, is an austerity program initiated by Detroit General Hospital, the major hospital in Detroit, resulting in the layoff of their alcoholism counsellor. The social worker still employed at Detroit General called HAP to take patients that couldn't be treated. Mrs. Schuman concluded that given the situation in the community, more staff could be used by HAP's alcoholism program to treat more patients. HAP's budgetary limits, however, have precluded this option for increased service to the community.

Kaiser Permanente Los Angeles Alcoholism Program*

The Kaiser Permanente Los Angeles Alcoholism Program is interested in developing a program similar to the Fontana social model detoxification unit, a part of the Southern California Kaiser plan located in San Bernadino County. They are exploring residential treatment capabilities for detoxification and early initiation of treatment (probably 5-10 days) to be followed by intensive outpatient treatment. The new program would probably not be situated within the hospital but in a separate facility.

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* The Kaiser Permanente Los Angeles contacts were Dr. Donald Gragg, Medical Director of the Alcohol and Drug Dependency Program and Dr. Sidney Rieff, former Medical Director.

Pressure from labor groups is being felt for the provision of inpatient residential treatment. Dr. Gragg, one of the Kaiser Permanente contacts, noted that the West Coast has not had inpatient units such as Mellwood Farm or Seneca House in the Washington, D.C. area. The reason for this is that California is now working on these regulations for a new category of facility for non-acute care residential treatment.

A change in the administration of the program came about in November of 1980. When Dr. Gragg became the full-time administrator, replacing Dr. Sidney Rieff. Dr. Rieff had been the Director in a half-time capacity. Dr. Gragg believed his arrival as the new Director and the publicity surrounding it was responsible for the increase in the number of referrals for treatment. He also felt his full-time status and being a specialist in the alcoholism field has strengthened the credibility of his program among providers.

Another staff change involved the departure of the senior counsellor/coordinator in July 1980 and the addition of a new one in December of last year. The program now has seven counsellors.

The program is moving in the direction of more group involvement as opposed to individual counselling visits. More A.A. involvement is also being encouraged.

Kaiser Permanente Medical Care Program - Oregon Region*

In January of 1979, the alcoholism program at Kaiser Portland was made a separate unit from the Mental Health Clinic. The program staff was dissatisfied with the mental health clinic's minimal commitment to alcoholics and with the clinic's general reluctance to become involved in alcoholism treatment.

The alcoholism treatment program hired its own counselling and medical staff and established its own center in a building provided by the plan. It was designated as an alcoholism treatment facility only. Three full-time experienced alcoholism counsellors were hired along with a full-time nurse practitioner. Dr. Ray Noel remained in the capacity of half-time administrator. The move to its own exclusively alcoholism-oriented center resulted in greater commitment to treatment for the addictive person as opposed to the previous emphasis on mental health.

In 1979, Kaiser Portland also adopted alcoholism as a full benefit. Prior to this time, the benefit had a 50% copayment. According to Dr. Noel, the new primary benefit has resulted in a better patient retention rate. When copayment was part of the benefit, patients would appear for an initial treatment visit, discover it required out of pocket expenses, and not return for the second visit. With the full benefit now provided, more patients are returning to be treated for an extended period of time.

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* The Kaiser Portland contact was Dr. Ray Noel, Director.

Dr. Noel believes this is leading to better treatment outcomes.

As of 1979, residential treatment as an option was all but eliminated. Experts questioned the value of 30 day patient stays; the skepticism was taken seriously by Kaiser-Portland management. Patients will be hospitalized for detoxification and are then continued in an intensive outpatient mode. In addition to inpatient detoxification, there has been in the last couple of years a greater utilization of outpatient withdrawal detoxification management. In the separate alcoholism program facility, Dr. Noel has been seeing patients daily where he will initiate detoxification in order to prevent a number of unnecessary hospitalization and unnecessary costs.

Since January of 1979, Dr. Noel has been seeing any patient who has requested Antabuse and has been discouraging the primary care physician from prescribing the drug. The program still uses Antabuse with forty to fifty percent of its patients but prefers to prescribe it primarily when the patient is in active treatment. Dr. Noel said Antabuse is being used more frequently.

Another change has been the utilization of recovering alcoholics as counsellors. There is also an A.A. meeting now available in-house. A crisis management team was instituted in January, 1981 within the emergency room on a 24 hour basis.

A stronger emphasis has been placed on the treatment of the alcoholic's family during the past year and a half. Family members are viewed as legitimate candidates for treatment even if the alcoholic is not in treatment. For the future, Kaiser Portland is planning to add to its staff more recovering alcoholics. It also plans to switch to a more intensive A.A. emphasized educational model of treatment and de-emphasize classical psychotherapy. Dr. Noel advocates a shortened course of treatment and use of recovering alcoholics as therapists.

The program has increased in cost with a fully paid staff replacing part-time mental health technicians. There used to be one full time equivalent (FTE), one screening social worker, one secretary, and Dr. Noel who devoted one-tenth of his time to alcoholism. The total amounted to approximately $60,000. Currently, there are four FTE counsellors (one functioning as a part-time administrator) one FTE nurse practitioner, one clerk-typist and Dr. Noel as a half-time physician director. In 1979, the budget for the new program rose from $60,000 to $160,000 and is currently about $200,000 annually which approximates 6 cents per member per month.

Patient load has also increased substantially in the last three years. In 1978, approximately 250 to 300 new patients were being treated a year. At the present time Kaiser Portland treats forty patients a month or 500 new patients a year.

Kaiser Permanente Medical Care Program, San Bernadino County, Fontana Alcohol and Drug Dependency Program*

As previously mentioned, the Fontana unit is a possible model for the Kaiser Permanente Los Angeles alcoholism program. Fontana has both "in-resident" and outpatient treatment available.

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* The Fontana contacts were Dr. Anthony Radcliffe, Physician-in-Charge and Dr. Rudy Garcia, Chief Counsellor.

The length of stay for in-resident treatment depends upon the patient's condition at intake and the severity of withdrawal. The average length of stay, usually seven days, is short in comparison with other inpatient programs. This aspect of Fontana makes it attractive to Kaiser Permanente and to other HMOs desiring to control the number of hospital days while simultaneously appeasing employers and labor groups pressuring for inpatient treatment.

The Fontana unit attempts to mold its program to the patient's individual needs rather than molding patients to its program. Fontana has received pressure from labor groups and employers concerning the short length of stay for in-resident treatment. Fontana maintains, however, that its philosophical outlook is more effective. Rather than having a standard, twenty eight day inpatient program, it tailors its program to the patient's needs. Some patients may need to stay longer than others, again depending upon the severity of the problem. Some patients may not need to stay away from their families or jobs for an extended period of time; their needs can be met effectively through outpatient care.

There are two types of withdrawal treatment at Fontana: "major" and "minor" withdrawal. The "major" withdrawal cases are treated in the acute care hospital across the street from the Alcohol and Drug

Dependency program's facility. Major withdrawal involves detoxification from both barbiturates and alcohol. Minor withdrawal is handled within the unit and is alcohol detoxification only.

Antabuse is not always used but it is sometimes an enforced adjunct of therapy.

The Alcohol and Drug Dependency unit staff consists of five outpatient counsellors who are trained recovering alcoholics, ten in-resident counsellors, one physician-in-charge (one other physician was shifted to internal medicine), two marriage and family therapists (both with Masters in Social Work), and one Nurse Supervisor who manages the clinic's facilities, finances and staff.

It is a ten bed, twenty-four hour per day facility. Therapy ranges from group therapy, to family forums conducted by the social workers, to educational programs, to individual therapy conducted by outpatient treatment counsellors. Each patient works with a prime care counsellor and longer range therapy is coordinated with this person, normally for a considerable length of time.

Alcoholics Anonymous, Al-Anon and Alateen are promoted and patients and families are oriented to these community resources. San Bernadino is the largest county in the country and patients come to Fontana from all over the county. They are referred to A. A. in their respective localities. Due to plan rules and regulations, an A. A. meeting previously held on-site has been discontinued.

Other groups have been formed, including a teen group, a women's awareness group, a "winner's" group consisting of former patients who return every Friday and Saturday night to share with patients, and a "Dual-users" group for marriage partners who are both alcoholic. The unit is also developing the use of biofeedback and an exercise program.

Dr. Radcliffe foresaw the need to expand in the future. The unit treats 100 to 150 patients per month. The ten beds are always full and more patients are being admitted all the time. There is also a need for day room activities, a volunteer program for recovered alcoholics willing to work, a child awareness program, and a physician awareness program.

Provider education has been conducted on a regular basis since 1974. Once a month one of the health departments, such as pediatrics or nurses in ICU, is given a talk on alcoholism. Education is provided for health plan members every three months.

Dr. Radcliffe speculated that cost for outpatient treatment and in-resident care (excluding hospital care) amounted to approximately $500,000 per annum. Cost per resident per day is between $60 and $90.

Summary and Conclusions

Generally, the four study sites have been providing the same basic services as described in the December, 1978 and the April, 1980 GHAA/NIAAA Alcoholism Within Prepaid Group Practice HMOs and Alcoholism Treatment Programs Within Prepaid Group Practice HMOs: An Update reports. Some things have changed, however, to refine and improve treatment of the alcoholic. Experience in the field has led to greater knowledge of both how to detoxify and treat the alcoholic more effectively and how to reduce costs.

There is a continuing trend towards outpatient therapy as a cost effective modality. Some interest was expressed in short-term inpatient treatment but for the most part the standard twenty-eight day residential program is an outdated modality for HMOs. Detoxification is also being done in some instances on an outpatient basis but most detoxification is still inpatient. Provider education has increased the number of patients being detoxified by providers before they are referred to the alcoholism program.

More Antabuse is being prescribed in all the plans. In part, this is also due to provider education. More physicians are being encouraged to prescribe the drug in addition to physician formally connected to the alcoholism program. It is being used as an adjunct to therapy more frequently to keep the alcoholic sober in the initial stages of treatment.

Most staffs have been enlarged to meet the demand for alcoholism services. The staff increase is especially true of plans in a growing economic environment such as the Arizona Health Plan. The opposite is true at the Health Alliance Plan in Detroit where a bad economy has decreased the staff and has limited the growth of the program even though the demand is high. One method of cutting costs for labor is to hire recovering alcoholics who are employable at a lower salary than professionals. Recovering alcoholics have a personal experience with the disease and often have a first hand knowledge of the treatment process. More social workers are also being used, often in connection with the increased focus on treatment of the alcoholic's family, showing an emphasis on alcoholism as a family disease.

The programs are much more A.A. oriented. Patients are increasingly referred to A.A. and the program is emphasized as an adjunct to therapy. Patients are also encouraged to continue attending A.A. in their own communities after leaving treatment. Al-Anon and Alateen are also emphasized for the family members. Some plans still have A.A. and Al-Anon meetings on-site.

A wide variety of new and innovative specialty groups have been developed. The growth of these groups reflects a greater refinement of the treatment process to meet the specific needs of individuals. It also reflects the economic status of the plans. Once again, the Arizona Health Plan at the present time has more resources for the development of these groups than does the Health Alliance Plan. The plans appear to be doing as much as they can to supply special care to meet increasing demand within their own economic constraints.

In general, budgets have increased, not only due to expansion of services but also because of increased costs for labor. Inflation has contributed to this problem, particularly since health care costs are rising much faster than any other facet of the Consumer Price Index (CPI). Administrators of these four programs are finding effective methods of treatment which simultaneously contain costs in conformity with the HMO philosophy. The effect is a general trend away from inpatient rehabilitation towards outpatient therapy and a greater emphasis on the A.A. alternative. Measures such as the innovative use of the HAP secretary for inpatient therapy may become routine when budgets are tight or the program's importance is de-emphasized by the plan's management for financial reasons. Considering the increasing awareness of the pervasive disease of alcoholism, the study plans will more than likely continue to increase their budgets and staff sizes to meet the greater demand for services.

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APPENDIX E:

TECHNICAL ASSISTANCE FOLLOW-UP

GHAA staff conducted a telephone follow-up of all technical assistance provided by GHAA consultants and staff during the course of the NIAAA demonstration grant and contract. Technical assistance was provided to prepaid group practice plans interested in the development and implementation of alcoholism services.

Much of the technical assistance was provided by Ross Landess, M. D., Director of the Alcohol and Drug Dependency Program at the Arizona Health Plan in Phoenix, Arizona. Dr. Landess was one of the major consultants for the project, lending his knowledge and expertise in the alcoholism field to numerous plans throughout the country and helping to initiate alcoholism treatment programs in the HMO plans he visited. Other consultants, such as Harold R. Hunter, Dr. P.H., now Director of GHAA's Research and Development Department, Peter Brock, now Director of the Johnson Institute, and Gary Jacobs, now Executive Director of Healthcare of Broward, Inc., also performed the technical assistance.

Prepaid plans from all over the country were motivated to respond to the solicitation for requests for technical assistance by a number of factors:

- pressure from employer groups
- potential cost savings
- perception of required services under federal regulations
- recognition of alcoholism as a member health problem

- competitive/marketing considerations.

Assistance was provided by phone, written correspondence or site visit. Experienced consultants were sent for a one-day on-site visit along with GHAA staff associated with the alcoholism project. The site visit team met with Executive, Medical, Marketing and Mental Health Directors, a designated physician advocate for the alcoholism program and primary care providers to discuss the following issues:

- treatment modalities
- staffing patterns
- referrals and patient flow
- relationship of the alcoholism program to the Mental Health Department
- costs/benefit of alcoholism treatment
- the role of physician and non-physician providers.

The GHAA consultants and staff also provided the plans with these materials:

- Alcoholism Within Prepaid Group Practice HMOs, (NIAAA grant no. 5H84 AA 01745), GHAA, December, 1978.
- Alcoholism Treatment Programs Within Prepaid Group Practice HMOs: An Update, (NIAAA Contract No. ADM 281-78-0021), GHAA, April, 1980.
- Alcoholism Services Handbook for Prepaid Group Plan, GHAA, March, 1979.
- Alcoholism in Medical Practice, A Brief Guide to Management,

Ray Noel, M.D., in cooperation with GHAA, December, 1978.

- "Alcoholism Update", bibliographic references by various subject headings, developed by GHAA Gertrude Sturges Library.

The general objective of the follow-up was to ascertain both the efficacy of the technical assistance and the present status of the alcoholism program of each prepaid group practice plan receiving assistance. The following ten questions were asked whenever applicable:

- Was the technical assistance helpful and effective?
- Has awareness of alcoholism treatment changed among your physicians and/or management?
- What is the status of your alcoholism program (i.e., does it emphasize inpatient or outpatient treatment or does it provide only detoxification)?
- Are you being pressured by local employers to change your alcoholism program or your benefits package?
- What is the current relationship between your alcoholism program and your Mental Health Department?
- How many patients per year do you treat for alcoholism?
- Do you provide information/education for the families of alcoholics?
- Do you use Dr. Ray Noel's monograph, Alcoholism in Medical Practice, A Brief Guide to Management?
- Are you affiliated with community alcoholism treatment facilities?
- Do you refer to A.A., Al-Anon and Alateen?

The following HMOs were contacted for the follow-up:

- Capital Area Community Health Plan--Latham, New York
- Community Health Care Center Plan--New Haven, Connecticut
- Connecticut Health Plan--Bridgeport, Connecticut
- Fallon Community Health Plan--Worcester, Massachusetts
- George Washington University Health Plan--Washington, D.C.
- Group Health Cooperative of Puget Sound--Seattle, Washington
- Group Health Plan--St. Paul, Minnesota
- Health Central--Lincoln, Nebraska
- Health Insurance Plan of Greater New York--New York, New York
- Health Service Plan of Pennsylvania--Philadelphia, Pennsylvania
- Kaiser Foundation Health Plan of Colorado--Denver, Colorado
- Kaiser Foundation Health Plan of Ohio--Cleveland, Ohio
- Manhattan Health Plan--New York, New York
- Philadelphia Health Plan--Philadelphia, Pennsylvania
- Ross-Loos Health Plan (now INA of California)--Los Angeles, California
- South Florida Group Health, Inc.--Miami, Florida

Capital Area Community Health Plan

The technical assistance provided was very effective in initially getting the program off the ground. According to the director of the alcoholism program, Dr. Landess, the consultant, contributed greatly to physician acceptance of alcoholism treatment and generally lent more credibility to the program.

Awareness of treatment of the alcoholic has improved to a great extent. Although there are still some negative and questionable attitudes among some physicians, the general change has been drastically positive.

The program's main thrust is outpatient treatment. The services include individual, group and couples counselling and an inpatient detoxification unit benefit.

The Capital Area Community Health Plan is not being pressured directly by employers. There is, however, indirect, "word-of-mouth" concern, mainly on the part of General Electric employees. This concern is with the lack of long-term inpatient treatment, a continuing theme in many of the follow-up calls.

There is a side-by-side relationship between the Mental Health Department and the alcoholism program.

The number of patients treated from February 1980 to February 1981 was 109.

The plan definitely stresses education and information for families of the alcoholics, as well as family counselling. Education includes an open house, public relations (including articles in the bimonthly newsletter), and an emphasis on physician training with workshops to help continue changing physician attitudes.

Dr. Noel's monograph is used as a protocol for outpatient treatment, detoxification, and Antabuse contracts.

The plan is affiliated with a community alcoholism treatment facility for detoxification, outpatient day treatment, and with a sobering-up station for social detoxification. The contact in the plan also has a personal relationship with other alcoholism directors in the area.

The program refers to A. A., Al-Anon and Alateen.

Community Health Care Center Plan, Inc.

A program was instituted last December for alcoholism treatment with a full-time counsellor, outpatient and inpatient and a relationship with an inpatient treatment center in coordination with CHCCP counsellor. The reason for the institution of the program was community pressure. CHCCP responded to the pressure by reinterpreting its alcoholism benefits in a more liberal fashion.

The program is fully integrated with the Mental Health Department.

In the last twelve months, non-Medicare enrollees have tallied 572 inpatient days for alcoholism treatment and Medicare enrollees have tallied seven days.

Information and education are provided to families of alcoholics.

The plan holds A. A. meetings on the premises and it is trying to get more involved in both A. A. and Al-Anon.

Connecticut Health Plan

As a preface to these comments, the Connecticut Health Plan has recently been bought by Blue Cross and reorganized. A year ago, CHP experienced financial difficulties and they reorganized through bankruptcy. As a result, they did not rehire their counsellor for alcoholism. W[illegible] stability, the plan should survive, but their population has been reduced and they don't have as many alcoholism referrals. They are now poking around in EAP. They couldn't obtain funds from the state and withdrew their application.

There has been pressure in marketing the plan from employers. Blue collar workers wanted inpatient capacity which is why CHP changed their benefit.

The counsellor provides information and education to families and there is a family forum and awareness night. An A. A. group has been started at the plan. A psychiatric social worker refers enrollees to A. A. and Al-Anon.

Fallon Community Health Plan

The technical assistance was considered to be "very splendid" by the Fallon contact. Great value was placed on the advice and recommendations of the consultant. Fallon now has a fully functioning program with two full-time counsellors.

Physician awareness has definitely increased, indicated by the existence of a program at the present where previously there wasn't one. The program consists of two counsellors relating to an internist who is the director. The counsellors get referrals and have appointment schedules and will hospitalize as necessary.

The program is conducted on the advice of GHAA consultants. They have in-house staff education and the primary emphasis is outpatient treatment.

The plan occasionally gets pressure from an employer who doesn't realize outpatient treatment is as effective as inpatient treatment. This is, at least, Fallon's attitude.

The program for alcoholism is functionally independent from the mental health department but information is shared and cases are discussed.

The program carries a full patient load with approximately twenty patients per day being treated for alcoholism.

Information and education are provided for the recovering alcoholic's family members. Fallon is not connected with any community alcoholism treatment facilities but it does refer to community resources such as A. A. or Al-Anon.

George Washington University Health Plan

Technical assistance provided encouragement for the plan's contact. It did not effect the administration, however, because there is little motivation to change at this point. Attempts that have been made to change have failed, even on an informal basis.

Because the turnover of physicians is high, newer doctors may not be as aware of alcoholism treatment as the longer term doctors.

Essentially, there is no formal alcoholism treatment program due to administration concerns. There is no provision of hospitalization coverage for detoxification. Enrollees must pay for their own detoxification unless there is medical jeopardy. If this is the case, they will admit them onto the medical unit. Alcoholics are treated on an outpatient basis, similar to patients' treatment in Mental Health Services, with encouragement to participate in A. A.

There is no pressure from employers to change the program, there is no provision of services for families of alcoholics, no information or education and no affiliation with community alcoholism treatment facilities.

George Washington University Health Plan does, however, refer to A.A., Al-Anon and Alateen.

Group Health Cooperative of Puget Sound

Originally, the program stood by itself but it now has been assimilated by the Mental Health Services Department. There is also a move towards a family practitioner connection. This, it was felt, will increase awareness of physicians to alcoholism treatment. Awareness, due to increased educational efforts, has been increased already.

The plan has detoxification centers and outpatient treatment is emphasized rather than inpatient treatment.

Information and education is being offered to families. GHC of Puget Sound is moving in treatment methodology toward involving families in group activities.

Some staff have experienced in community alcoholism treatment facilities, but there is no formal affiliation.

The program is very closely connected with A.A., Al-Anon and Alateen. They did at one time have an introductory A.A. meeting within the plan's facilities.

Group Health Plan, Inc.

The Group Health Plan has a staff of three or four counsellors. The program involves drugs as well as alcohol. The staff has been increased in the last couple of years. They have tried to achieve better management by putting controls on inpatient facilities use and treatment by emphasizing the less costly nature of and the efficacy of outpatient treatment. The entire program, it was felt, will be more effective if it is under greater management control.

The technical assistance consultant visited at a time when the alcoholism program was either non-existent or small in scope. The fact that the program has developed since then is indicative of a problem of alcoholism in the Group Health Plan and a recognition of federal requirements as well.

Physician awareness has increased at GHP. This increased awareness is the result of an increase of staff which is in a position to respond quickly to referrals. There is a better response time, members being seen for initial assessment in a day. Also, more alcoholic patients are being identified earlier with the increased staff. The ready availability of service attracts enrollees at an earlier stage of the disease's development. By steering members into outpatient treatment at this earlier stage, breakdown of the family and the inability of the alcoholic to live a conventional lifestyle can be avoided.

Pressure by employers is particularly interesting in the Twin Cities area. Employers have a history of being involved in alcoholism treatment. It is common in the area for an employer to have an alcoholism counsellor on staff, or a person concerned with alcoholism, steering employees into treatment. There are also industrial counsellors, often recovering alcoholics, who have a strong allegiance to a particular community treatment facility with which they have had personal experience. The general tendency of the area is a strong orientation towards inpatient treatment in a particular treatment facility.

Group Health Plan's strategy is to try to demonstrate that outpatient treatment is as effective as inpatient treatment. It is less costly for employers because of cheaper premiums and because employees are not off the job for a month or two weeks as they would be in inpatient treatment. Pressure from employers has been more significant in the past as employers are beginning to become receptive to the validity of the outpatient argument.

The member contract language has recently been changed to provide for inpatient treatment only if referral is by internal staff in order to acquire greater management control.

There have been meetings with employers and correspondence between counsellors and employers and benefits representatives. Employers are more and more concerned with the acceleration of health care costs and are more receptive to the less costly outpatient argument. The trend, therefore, is in the opposite direction, from strong emphasis on outpatient treatment to receptivity to a good outpatient program.

Group Health Plan will have a tougher stance on referrals in the future and will possibly impose copayment for inpatient treatment. This latter idea will be another lever to use to encourage patients to consider outpatient treatment.

The alcoholism program and the mental health department split up a couple of years ago and are not now part of a single program. They were physically and administratively separated because they couldn't be accommodated in the same facility. Now, however, the plan is bringing the two departments back into physical proximity in a building just purchased. Closer proximity will be useful for cross-treatment consultation and departmental interchange. It was felt at the time of separation that the alcoholism program was not getting sufficient emphasis. Group Health now wants to recruit personnel who are able to work in both alcoholism and mental health.

Information and education is provided to families of the alcoholic patients. All treatment of alcoholics is done by outside providers whether it is inpatient or outpatient. The providers include members of families in treatment. GHP staff conducts follow-up of all treatment which may include spouses in group sessions.

The plan is not formally affiliated with community alcoholism treatment facilities and does not regularly use county sponsored community chemical dependency programs. They use privately sponsored facilities once in awhile. This lack of affiliation does not preclude communication within the industry. The program does refer to A.A., Al-Anon and Alateen.*

Health Central (Lincoln)

The technical assistance provided to Health Central in Lincoln was very helpful, not primarily because of the technical content, but because it raised the consciousness of staff members and interested, but extremely hostile, people in the community. Health Central mainly reaped public relations benefits from the visit.

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* Note that Minnesota has a state law requiring that alcoholism and mental health be offered by group insurance carriers which includes HMOs.

The plan has hired a clinical psychologist with an outpatient background since Dr. Landess visited. The clinical psychologist hired works with the Medical Director, Dr. Lucas, in the treatment of alcoholics. Dr. Lucas mentioned that he would like to use GHAA expertise in the future as further questions arise.

Physician awareness was augmented by the consultant's visit and subsequently there have been some intervention sessions for the staff. This increased awareness has doubled the identification of patients with alcohol-treated problems. Health Central lost credibility in the community for changing from a Johnson model, 30 day inpatient program to outpatient treatment. They received criticism, pressure, and bad press because of this change and felt it would take a long time to change the community's attitude back to a positive one once again. The change threatened the traditional provider community. Health Central has attempted to alleviate this criticism by hiring a Ph. D. to run the alcoholism program who was already well regarded in the community. By doing so, Health Central has already improved its credibility somewhat, both in the community and with the plan's own physicians and psychiatrists. If they had begun with a "light-weight", the contact said, the program's credibility would not have been enhanced.

The Mental Health Department and the alcoholism program are distinctly separate although the clinical psychologist they hired spends 50% of his time on alcoholism and 50% on mental health. These departments have separate budgets and this is the main reason for the division.

Practically speaking, though, they are well integrated, there is good teamwork, and they share responsibility in such activities as setting up family groups.

For a population of approximately 10,000 members, they have generated 15 patients in two months. All together, fifty to seventy-five enrollees have entered alcoholism treatment since the program's inception, but about two hundred have been evaluated for the possibility of alcohol-related problems.

An education and information program for families is being set up to include pamphlets, newsletters, outreach and screening.

The Noel pamphlet is being used for detoxification.

The plan is not affiliated with community alcohol treatment facilities but it does refer to A.A., Al-Anon and Alateen.

Health Insurance Plan of Greater New York

One prefatory remark to HIP's response is that it is not federally qualified and therefore is not required to offer the alcoholism benefit. HIP is composed of quasi-independent groups of doctors. Mental Health is centralized into three centers and each group refers to one of them.

Technical assistance was very helpful and effective. It answered many questions and gave helpful advice. The result was that HIP offered further services. The plan has, however, proceeded slowly in alcoholism treatment and hasn't followed up on the site visit too strongly.

Physician awareness has not changed according to the contact but hopefully it will. Physicians practice in 20 quasi-independent groups.

The alcoholism service is not given to the entire HIP population but it is a rider for certain groups. Some members can get detoxification only and others can get full alcohol treatment, including follow-up group therapy, individual therapy, and referral to community resources. Federal employees and the medicaid population get intermediate care, or 30 days "drying out" in certain city institutions.

The alcoholism rider is marketed and a fair number of organizations appear to be interested and purchase it. Of all new HMO contracts, 70% want it. The biggest subscribers are city employees. Many individuals raise questions about benefits, constituting a certain degree of indirect pressure.

The Mental Health Department administers the alcoholism program.

The statistics for 1980 show that utilization for detoxification is 1.2 per 1,000 and the average number of days hospitalization/patient is seven.

Dr. Noel's monograph has probably not been used significantly.

The program is affiliated with community alcoholism treatment facilities and does refer to A.A., Al-Anon and Alateen.

Kaiser Foundation Health Plan of Colorado

The meeting in Hawaii of the Kaiser regions was very helpful in opening the plan's eyes and in motivating them to initiate change. There was no question about the efficacy of the meeting in increasing physician awareness. Previously, Kaiser-Denver treated fifty patients for alcoholism per year. After the meeting in Hawaii, the plan treats twenty times that amount. Kaiser-Denver primarily has a benefit of inpatient detoxification and rehabilitation. The greater Denver area has one of the largest number of community programs in the country, including treatment of adolescents, retirees, and all those in between. Kaiser-Denver refers to community resources and an outpatient Personnel Assistance Program. Employers appear to be happy with the program.

The alcoholism program is not part of the Mental Health Department.

There is identification of significant others and disturbed children for treatment in addition to the alcoholics themselves.

Kaiser-Denver is affiliated with community alcohol treatment facilities, has visited program on-site and does refer to these programs.

The program is conceived of as an early identification program and a bridge to A.A. The Noel monograph is used extensively in physician education and references.

The contact mentioned he would like to see another meeting like the one in Hawaii.

Kaiser Foundation Health Plan of Ohio

The technical assistance was good and necessary but the plan's management did not respond quickly to the consultant's recommendations. As a result the plan has moved slowly and progress has been minimal.

One improvement, however, has been the hiring of two lay counsellors who have taken over the intake of alcoholics. These employees have done a good job in counselling and in follow-up that the mental health staff didn't previously have time to do. Many programs within the alcoholism services department have been initiated by these lay people who have been very innovative as a whole. These programs have included sessions for community people and the program has also been tied very closely to A. A. and A. A. sponsors by the new counsellors.

One problem area has been that patients do not like the fact that hospitalization for detoxification is in the mental health unit. There is resentment about this because alcoholics do not want to be associated with mental health.

The objection to not being in the hospital for 14-28 days is dwindling. The basic benefit is detoxification. Alcoholism is a free-standing benefit. The counsellors refer patients to certain community agencies which are effective and members pay according to their abilities.

As far as physician awareness goes, physicians as a group treat private individuals for alcoholism on their own. Pediatricians seem to be becoming more aware of the problem but Ob/gyn's remain relatively unaware of the program. The emergency room could be educated further to identify and refer alcoholics (they are aware of the nuisance of alcoholics in their ward but are unaware of what to do for them). There is a need for education in internal medicine as well. Physicians are showing signs of mild interest in participating in a formal program. Ms. Baldi indicated that the program could begin with internal seminars for specific departments, and then proceed step by step rather than rushing in and alienating people.

With the advent of Employees Assistance Programs in previous years, Kaiser found it was included as a provider to discuss employees who were Kaiser members with EAPs. The employees of the EAPs closely identified with Hazelden or the detoxification-rehabilitation approach and would like to see this covered. The contact at Kaiser mentioned that they are not being approached as they would be for any other benefit but they are under pressure from unions and recovering alcoholics. These groups, however, are becoming less virulent and critical.

The Kaiser contact did not know the number of patients per year because alcoholics are hospitalized in the mental health department and are not separated out. The rate, it was estimated, is not significantly high although there are times when the 25 bed mental health unit is predominatly occupied by alcoholics.

Information and education is provided to families. Many programs have been developed for the spouses and children of alcoholics and referrals are made to Al-Anon and Alateen. The family programs get a very good response.

Manhattan Health Plan

The visit by the consultant provided information on ways to proceed in developing programs and with clinical information for different groups. All of this was found to be useful.

The plan is waiting, however, written documentation of GHAA's recommendations in order to institute an alcoholism program. They want to hire an alcoholism counsellor and want alcoholism to be separate from mental health.

Awareness of the problem of alcoholism has increased since the consultant visited the plan but the awareness is insufficient.

As far as employer pressure goes, alcoholism is quite an issue among white collar workers in Manhattan. Employers welcome any beneficial change in this area. Since the time of the visit the plan has been liquidated as a separate entity, absorbed by HIP, and has become one of their participating provider groups. A separate alcoholism component in a single group will mark a departure for HIP in substance abuse services.

Philadelphia Health Plan

PHP is a network of six groups operating in ten sites throughout Philadelphia. The medical director of PHP said that at the time of the TA there was interest in developing a program and the technical assistance built momentum but was superseded by issues of plan survival.

Physician awareness was not increased by the technical assistance since it was targeted solely to management rather than to provider. This seems to contradict the fact that assistance was provided to physician representatives of the medical groups by Drs. Landess and Hunter. Several subsequent meetings were held with other city alcohol programs for interchange of ideas.

PHP now provides service as a standard mental health benefit. The medical group renders necessary treatment to alcoholic patients but there is lack of physician awareness and insufficient case finding. A physician education program was what was felt to be needed.

No information on the number of patients treated per year was available.

Each medical group handles information/education for families differently depending upon preferences of mental health staff.

PHP is currently being reorganized under the state bankruptcy laws and is likely to be acquired by another plan.

Ross Loos Health Plan (now INA of California)

The technical assistance was extremely helpful. The contact was, at the time of the technical assistance, a receptionist finishing her masters degree in psychology and there was no one in alcoholism treatment. All alcoholic problems were referred out. The contact went to the Arizona Health Plan in Phoenix on the advice of the GHAA consultants and at GHAA's expense to observe the outpatient program there. The contact said that GHAA's technical assistance was key to Ross Loos having anything to do with alcoholism. GHAA's subsidy to pay for the provider's training at Arizona Health Plan stimulated the development of the outpatient alcoholism program in the HMO. Furthermore, AHP's good track record gave the contact the evidence necessary to convince the administration it would work at Ross Loos as well.

Ross Loos now has an outpatient program with a Psychiatrist as Chief, three alcoholism counsellors and a social worker. Treatment includes group, education, films, couples therapy, family-marital therapy, and family evaluation.

There is a detoxification benefit of 15 days per year which covers two courses of treatment. Two facilities are used for detoxification and outpatient treatment.

Ross Loos' desire is to have an inpatient program modelled on Kaiser's Fontana program (a recovery, non-medical unit for 7-14 days of inpatient treatment) and to open up more outpatient units.

Physician awareness has changed, causing the creation of an outpatient program. All subscribers are covered for services.

Ross Loos is being pressured by employers to increase services to include longer term inpatient care. Ross Loos' argument against this is that even if members are entitled to 28 days, they aren't necessarily in need of such a long stay. They believe in individualized treatment--some members may not need to stay for 28 days but some may. Staff is pressuring for EAP within Ross Loos to have services for their own employees.

Alcoholism is currently part of the Mental Health Department. It may not remain so because they then may have to hire more staff.

In 1980, approximately 512 members were treated for alcoholism. In one month, in December, 4,000 patient hours were tallied.

Dr. Noel's monograph is used for the antabuse contract.

In their two year program, the patients must go to A.A. at least once a week and the program refers to Al-Anon and Alateen as well. A.A. meetings are hosted in the main office.

South Florida Group Health, Inc.

The technical assistance was moderately effective. At the time, South Florida was in the process of determining whether to become qualified, determining their configuration (they became a qualified IPA) as well as designing benefits. They decided it was too expensive to offer a full-fledged program as a small HMO.

The technical assistance provided by GHAA gave factual back-up for what they already had thought. They are county-wide and would have difficulty relating to a centralized facility.

The contact said that physician awareness has not really been increased because they haven't been too involved. Further the number and type of physicians has greatly increased.

If a member is determined to be an alcoholic, they treat with detoxification and then refer the patient to outside programs but do not pay for referrals. They do cover acute care, detoxification, and medical problems connected with alcoholism.

No significant pressure or demand from employers has been noted.

The alcoholism program and mental health department are not formally linked but there is informal communication between them to determine the best type of care.

Information is provided to families through primary care providers. South Florida Group Health, Inc. reflects the difficulty of maintaining consistency of interest in an IPA with numerous dispersed providers.

Health Service Plan Pennsylvania

Health Service Plan of Pennsylvania did not go ahead with the development of a grant proposal for alcoholism services but devoted the time, effort and resources towards a Medicare grant instead. There had also been talk about initiating an Employees Assistance Program as another source of revenue, but this program was not developed either. The plan did proceed with the development of an outpatient detoxification program which has been successful.

The technical assistance received was helpful primarily because it informed Health Service Plan of Pennsylvania of what other HMOs were doing and what was possible. It was also helpful in reinforcing physicians who were advocating going against the community standard of thirty day inpatient treatment to outpatient treatment. The ambulatory detoxification has been successful even though they have had a hard time convincing the community that it is effective. The general sense is that you need to detoxify in a hospital for three to four days and then rehabilitate for thirty more on an inpatient basis.

Physician awareness was increased because of the technical assistance. There was one physician, an internist doing a psychiatric residency, who was interested in generating an alcoholism program. There was skepticism among other physicians about his ideas and the technical assistance proved to be helpful in removing the other physician's doubts.

There has not been any significant employer pressure. There was more pressure two years ago, but even then it involved corporations such as TWA or Bell Telephone comparing their own programs with that of HSP's. Some pressure does occur when an employee, who would have been covered for thirty days rehabilitation under Blue Cross, complains to his employer that he isn't receiving the same benefits from an HMO and the employer in turn confronts the Health Service Plan of Pennsylvania with this grievance.

The alcoholism program is part of the Mental Health Department.

The contact at HSP had no idea how many patients are treated per year for alcoholism.

Information and education is provided to families of alcoholics.

HSP is not affiliated with community alcoholism treatment facilities but it does refer to A.A., Al-Anon and Alateen.

Summary and Conclusions

Generally, where the technical assistance was effective, it was very effective, helpful, and welcome. According to the follow-up conversations, seven out of the sixteen plans interviewed found the technical assistance very effective in either initiating or augmenting the efficacy of alcoholism services. As for the remainder of the plans, progress was hindered by more pressing financial problems in two HMOs, management did not respond favorably in three others, and the other four either didn't comment or were awaiting written recommendations on how to proceed from GHAA. The technical assistance, in other words, is most effective where it is warmly received by both the alcoholism treatment staff and upper level management, particularly in financially viable HMOs. Indeed, alcoholism treatment cannot become a priority until the HMO has a fiscally sound operation and a viable delivery system. Nevertheless, HMOs all do something.

The awareness of alcoholism treatment has changed dramatically in some plans, as evidenced by the increase of identified patients for alcoholism treatment. This phenomenon is typical of eight out of the sixteen plans. In the other plans the increase of awareness has been minimal and it varies among providers.

Out of the sixteen HMOs, ten emphasize outpatient treatment with most offering detoxification as well. The rest either have no formal program or are geared toward inpatient rehabilitation. Two HMOs either had changed from outpatient to inpatient treatment or wanted to include inpatient treatment in their benefits package.

Six HMOs said they are currently receiving no pressure from employers to change alcoholism benefits. In the remaining ten HMOs, pressure has been or is still being applied by employers to increase benefits from outpatient to inpatient treatment. Some have even initiated their programs because of this pressure. A couple of plans are trying to educate employers to the benefits of retaining outpatient treatment because premium costs are less and because employees are absent from the job less frequently.

Nine out of the sixteen plans said their alcoholism programs were integrated with the mental health departments. The remaining seven HMOs, however, said that although the alcoholism programs were separate from the mental health departments, the two departments did interact.

Ten of the HMOs did not have any information on how many patients per year are treated for alcoholism. In the rest of the plans, the number of patients per 1,000 enrollees per year treated for alcoholism was estimated to vary from .5/1,000 to 3/1,000 to 4/1,000 to 5/1,000 to 10/1,000.

Four HMOs did not provide information or education for families of alcoholics. The remaining twelve definitely did provide this service, some even to the point of including families in treatment of the alcoholic or identifying significant others and/or disturbed children for treatment. Most of the programs for families received a good response.

Dr. Noel's monograph is used extensively in only four of the sixteen plans for detoxification and Antabuse contracts as well as protocol for outpatient care at the Capital Area Community Health Plan. It is not used in the rest of the twelve HMOs.

There is no affiliation with community alcoholism treatment facilities for thirteen of the plans and three said that they do refer to these facilities on some basis.

Only three of the sixteen plans did not mention referral to A.A., Al-Anon and Alateen. All of the rest did, some mentioning they held A.A. meetings on-site and one called A.A. the backbone of their entire program.

GLOSSARY[*/]

1. Aftercare -- The process of monitoring and assisting the progress of clients who have been discharged from a residential or other treatment program. Important to the continued recovery of the client, it ensures that the accomplishments of treatment are retained.

2. Alcoholism -- An illness in which those afflicted habitually lose control over the amount of alcohol they drink to the detriment of their health or disruption of their social and economic life. No absolute definition of alcoholism based on volume consumed, social setting, or time of day is valid. An alcoholic is basically a person who cannot drink in a responsible manner.

3. Alcoholism Counselor -- Person familiar with the manifestations of the illness of alcoholism who guides clients to sobriety, and maintains a close personal working relationship with clients. Some counselors are recovering alcoholics themselves; some have professional counseling training. They are an essential element in a successful treatment program.

4. Detoxification -- The process of recovering from the effects of an overdose of alcohol. Detoxification services are sometimes offered in hospitals, clinics, or alcoholism treatment centers. Most persons suffering from an overdose do not need medical treatment, but some develop medical complications--such as delirium tremens--and must be hospitalized.

5. Early Intervention -- Prevention of acute alcoholism by confronting alcoholics in milder stages of the illness when symptoms first appear, and urging them to seek treatment. A successful technique, particularly when used by employers to aid workers with alcohol problems.

6. Education -- An important element of any alcoholism treatment and prevention program, education disseminates information to the community on alcoholism, alcohol abuse and the availability of treatment. It can provide valuable support for the program, increase awareness of symptoms of alcoholism, and lessen the social barriers to seeking treatment. Many forums are available for education, including news media, school programs, and presentations to community meetings.

7. Emergency Care -- Provides 24-hour evaluation of inebriated persons to determine their medical condition, need for services, and appropriate referral for care or treatment. Offered at a recovery house, hospital or clinic.

[*/] Based on Joint Commission on Accreditation of Hospitals (JCAH) definitions.

8. Half-Way House -- Sheltered living environments staffed by counselors who help alcoholics face their problem and re-enter the community. The format is flexible--some patients are full-time residents, some work and return at night, some come during the day for counseling. Clients are in all stages of recovery.

9. In-Kind Services -- Offered by counties or community organizations in addition to, in lieu of, or in return for program funds. Agreements may be made between counties and states, counties and community organizations, or separate county departments. An example of in-kind service is provision of bookkeeping help in exchange for treatment of county clients.

10. Inpatient Care -- Usually treatment in a medical or clinical facility providing 24-hour medical supervision. Alcoholics sometimes require this level of care for treatment of alcohol overdose.

11. Medical-Model Program -- Utilizes technically trained personnel such as doctors, psychiatrists, nurses, and psychiatric social workers. Treatment is offered in a hospital or clinical setting. The treatment period is shorter and more medications may be prescribed (such as tranquilizers) than in social-model programs--which frequently discourage drug usage.

12. Outreach -- Contacting people in the community who need alcoholism treatment or who know alcoholics. Informing the community at large of the availability of services.

13. Public Inebriate -- Person drunk in public. Commonly understood to mean "skid-row" alcoholics who may have no home to retreat to and thus cannot avoid being drunk in public.

14. Recidivism -- There is no common understanding of the word. "Rate of recidivism" may indicate the number of alcoholic clients who return to the same treatment center within a certain time-period, number who are arrested for public inebriation, number who go on binges, or number who take as little as one drink after treatment. It cannot be equated with "rate of failure." Alcoholics can slide back and still continue the process of recovery.

15. Recovery House -- Our term indicates a model half-way house or other residential facility that provides intake, referral, or counseling services.

16. Sobriety -- In the sense used in the alcoholism treatment field, it is the establishment of moderate or abstinent habits of drink.

17. Social-Model Program -- Utilizes alcoholism counselors to work intensively with clients. Alcoholics Anonymous usually plays a strong role. Treatment is generally offered in a half-way house or outpatient setting. Meetings are informal; the atmosphere is strongly supportive.

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